DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	380082	A. BUILDING _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE MILWAUKIE HOSPITAL	10150 SE 32ND AVENUE MILWAUKIE, OR 97222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS PLEASE NOTE that this report also includes Tag A-9999. This CMS 2567 report reflects the findings of an unannounced, onsite Federal EMTALA investigation of complaints OR46920 and OR43003 that was initiated on 12/19/2023, extended twice secondary to additional information received, and concluded with an exit conference on 02/15/2024. The hospital was evaluated for compliance with the EMTALA requirements set forth at CFR 489.20 and CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases (CMS Appendix V). The complaint allegations were substantiated. The deficiencies identified as result of the survey follow in this report. Although the hospital had initiated an internal investigation, and had self-reported an incident involving Patient 19 to OHA on 12/15/2023, it had not taken actions prior to the SA investigation to mitigate the possibility that a similar event could recur while its internal investigation was conducted and corrective actions were planned. Therefore, the following survey actions were taken as result of the survey team findings: * On 12/21/2023 at ~ 0830 the survey team conducted a meeting to review survey findings for potential IJ. Review of video-recordings, interviews, and record review to that point in the survey reflected the following events and gaps that occurred for Patient 19 on [redacted]2023. Those gaps created opportunity for a similar incident to recur and are described more fully in Tag A-2406	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/29/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 of this report. A draft IJ template for Tag A-2406 was initiated. * On 12/21/2023 at ~ 1200 the survey team met with the SA Section Manager to confirm the IJ in relation to the survey findings. The draft IJ template for Tag A-2406 was reviewed and finalized. * On 12/21/2023 at ~ 1300 the survey team presented the completed IJ template to the hospital CEO and other leadership staff and gave instructions regarding removal of the IJ. * On 12/22/2023 at ~ 1930 the survey team received a final draft of an IJ Removal Plan which outlined actions that included, but was not limited to: - Development of a detailed process for review of all discharges of houseless and other vulnerable patients prior to their discharge by ED RNs who would be trained to conduct the review. The RNs were to escalate a patient discharge concern to an ED IDT that included the MD prior to the patient's discharge. The details of the "Vulnerable Patient Discharge Safety Review" process are described further in this Tag below. - VPD process training for all ED staff, including physicians. - VPD competency process the ED RNs. - EMTALA training for all ED staff, including physicians. * On 12/22/2023 at ~ 1945 the IJ Removal Pan with a full implementation date/time of 12/28/2023 at 1000 received preliminary approval by the survey team, and the hospital was notified of the preliminary approval. * On 12/26/2023 at ~ 0830 the IJ Removal Plan was reviewed by the SA Section Manager who concurred with the survey team approval. * On 12/26/2023 at ~ 0940 the hospital was informed that the IJ Removal Plan was approved.	A 000		

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A 000	Continued From page 2 * On 12/28/2023 at ~ 1230 the survey team initiated an unannounced, onsite IJ removal verification visit and verified that the actions contained in the approved IJ Removal Plan had been fully implemented. * On 12/28/2023 at ~ 1550 the survey team informed the hospital that the IJ was removed, and at 1700 the survey team conducted the investigation exit conference. * On 12/28/2023 at ~ 2030 the survey team notified the SA Section Manager and CMS of the findings of the IJ removal verification visit. The survey findings resulted in the following EMTALA violations: * A-2400: Compliance with CFR 489.24 * A-2402: Posting of Signs * A-2405: Emergency Room Log * A-2406: Medical Screening Exam - Tag for which IJ was identified and removed * A-2409: Appropriate Transfer ********** * The hospital's IJ Removal Plan approved on 12/22/2023 reflected it would be implemented on 12/28/2023 at 1000. Implementation was confirmed during an onsite verification visit on 12/28/2023. The Removal Plan included the following process: "Vulnerable Patient Discharge Safety Review Plan - o Identification of vulnerable patients that may prompt reassessment to include but are not limited to: Patients with a Change in condition since MD Evaluation; Patients discharged to or back to houselessness; any patient or visitor refusal to discharge; any team member, patient, visitor, or prudent layperson raised concern with	A 000		

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A 000	Continued From page 3 discharge safety or destination; any patient requiring security escort off premises or contact with law enforcement for discharge, etc. o Once identified, the VPD competent RN will review: - Vital Signs are up to date. - Patient current condition assessment and reassessments are complete and clearly documented. - Provider has been notified of any new symptoms or change in condition. Documentation reflects. - Brief chart review to ensure care is complete and check for thorough documentation throughout visit. o Notify Charge RN of review. o If concerns are not resolved after VPD competent RN review proceed to huddle with Interdisciplinary team o Interdisciplinary team review must include the Attending Provider, VPD competent RN, Charge RN, and Direct Care RN and may also include Social Worker. - Review the discharge plan with the Attending Provider. If no longer on shift, escalate to available Provider. - Review possible assumptions made about this patient and discuss the risks if these assumptions are incorrect. - What more might be required by EMTALA to ensure this patient is safe to discharge. o Provider confirms Medical Screening Exam is complete and appropriate medical treatment has been provided prior to discharge. o Charge RN agrees that the discharge plan is safe and appropriate for patient. o If the Charge RN cannot support the discharge plan, they will immediately escalate any concerns using SBAR and the CUS tool utilizing the Chain	A 000		

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of Command before the patient is discharged.
Escalation path:
- Acute care RN
- Charge RN
- House Supervisor RN or department leadership
- Administration or Administrator on Call
- Further escalation will be initiated as appropriate by administration

o Concerns requiring escalation will be documented in the event reporting system for further investigation and follow up.
o Charge RN will collect and submit all VPDs to the department leader or designee. 100% of VPDs will be reviewed daily by the department leader or designee to ensure compliance and provide feedback to involved caregivers or other follow up."

* On 01/31/2024 during review of additional patient records secondary to the survey extension, surveyor findings included that the VPD process had not been completed for all vulnerable patients. The EDM stated that as result of IJ Removal Plan daily internal monitoring and audits the hospital had also identified gaps in the VPD process. They had found that the VPD review had not been followed for all encounters of patients who were considered vulnerable. The EDM stated that a number of actions had been taken to respond to those findings, including additional education.

* On 02/01/2024 an additional onsite visit was conducted in response to survey findings that the VPD process had not been fully implemented after the IJ Removal Plan Verification Visit. VPD monitoring/audit records and documentation of follow-up/response to audit findings was provided and confirmed. During the 02/10/2024 visit it was

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A 000	Continued From page 5 found that 7 of 15 records reviewed of patients who presented to the ED after the IJ Removal Plan Verification Visit on 12/28/2023 lacked evidence of the VPD review in accordance with the IJ Removal Plan. Those are as follows: - For Patient 21, who was houseless and demonstrated behavioral health/psychiatric symptoms during five encounters on [redacted]2023, [redacted]2024, and [redacted]/2024, a VPD review for each visit was not documented or was inadequate as described under Tag A-2406. - For Patient 23 the ED log reflected they presented to the ED on [redacted]/2024 at 1411 with a "Chief Complaint" of "Homeless; Insomnia." The "ED Disposition" on the log was "Discharge" on [redacted]/2024 at 1756. There was no VPD review documented for this encounter. - For Patient 26 the ED log reflected they presented to the ED on [redacted]/2024 at 1521 with a "Chief Complaint" of "Overdose (Accidental); Chest Pain." The "ED Disposition" on the log was "Discharge" on [redacted]/2024 at 1702. RN triage notes reflected the patient had additionally fallen in the shower that morning, had taken an "uber" to get to the hospital, and was at "moderate risk" of suicide based on responses to the suicide screening questions. MD notes reflected they had a "history of schizoaffective disorder, anxiety ... reports that [they had] been having increased symptoms of anxiety for the past several days ... has been using [their] hydroxyzine [anti-anxiety drug that causes sedation] more than [they are] supposed to ... about an hour ago [they were] feeling some chest tightness and feelings of shortness of breath and rapid heartbeat ... likely related to anxiety and a panic attack at this time."	A 000		

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A 000	Continued From page 6 There was no VPD review documented for the encounter of this patient who could be considered "vulnerable" secondary to history and presentation. - For Patient 28 the ED log reflected they presented to the ED on [redacted]/2024 at 1818 for a "Mental Health Evaluation." The "ED Disposition" on the log was "Discharge" on [redacted]/2024 at 2121. RN triage notes reflected that "Pt reportedly states [they were] going to kill [themselves], but deines [sic] SI to EMS and this RN, stating it was just to get attention. Pt denies SI and is seeking social work help for better living conditions." The RN notes further reflected "Thoughts of Suicide: Yes ... Impaired judgement ... Lacks insight ..." MD notes reflected the patient had a "history of depression, says abuse, anxiety reported getting into argument with [parent in-laws] and [the patient] held a knife to [their own] neck to get a reaction out of them. Denies any SI or HI ... [The patient] was seen by social work was not felt that patient was a danger to [themselves] or others ... I felt that the patient's clinical picture was most consistent with adjustment disorder." Although an extensive QMHP evaluation was conducted that indicated discharge was appropriate, there was no VPD review documented for the encounter of this individual considered "vulnerable" secondary to behavioral health concerns. - For Patient 30 the ED log reflected they presented to the ED on [redacted]/2024 at 2147 with a "Chief Complaint" of "Suicidal Thoughts." The "ED Disposition" on the log was "Discharge" on [redacted]2024 at 1449. RN triage notes reflected the patient was "BIBA after ... getting a knife and threatening to kill [their sibling] and then [themselves. Pt denies SI and HI." MD notes	A 000		

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reflected the patient reported "... getting into argument with [their sibling] and [they] pulled a knife out and threatened [their sibling] and then held it to [their own] neck and threatened to kill [themselves]. Upon arrival here [the patient] denies SI and states that [they were] impulsive and was trying to scare [their sibling] ... I felt that the patient's clinical picture was most consistent with adjustment disorder." Although an extensive QMHP evaluation was conducted that indicated discharge was appropriate, there was no VPD review documented for the encounter of this individual considered "vulnerable" secondary to behavioral health concerns.

- For Patient 31 the ED log reflected they presented to the ED on [redacted]024 at 1505 with a "Chief Complaint" of "[Ambulance]." The "ED Disposition" on the log was "LWBS before Triage" on [redacted]/2024 at 1526." The AMR ambulance report reflected staff at a shelter called 911 because they thought the patient overdosed on drugs. Upon arrival patient reported that they felt "bad" but they were unable to explain why. A "language barrier" impacted communications as well. EMS "Primary Impression" was "Toxilogical." Once at PMH, RN triage notes reflected "Triage RN out to lobby to call another pt. Pt openly asking RN in lobby if [they] can leave, while sitting in wheelchair. RN updated pt that [they are] able to leave if [they] would like. Updated pt that if [they want] to see a doctor [they] will need to be seen in triage and assessed by RN and MD ... Pt told admitting staff that [they] would like to leave. Able to get [themselves] out of the wheelchair, ambulate out the doors on own. Security walked with pt to make sure [they are] able to get where [they are] intending to go." There were no MD or MSE notes. There was no indication that the

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patient had been encouraged to stay for an MSE or had been informed of the risks of leaving without an MSE. There was no indication what transportation the patient who arrived by ambulance would be using to leave the hospital. There was no VPD review documented for the encounter of this patient considered "vulnerable" secondary to shelter living, lack of transportation, and possible overdose or "toxicological" adverse effect.

- For Patient 32 the ED log reflected they presented to the ED on [redacted]/2024 at 1805 with a "Chief Complaint" of "Overdose (Intentional)." The "ED Disposition" on the log was "Discharge" on [redacted]2024 at 1120 1526." RN triage notes reflected the patient took a large quantity of prescription and OTC medications and "reports that [their] intention was to end [their] life ... reports 'I feel numb to everything.'" The RN notes reflected that the patient's "Suicide Risk Level" was "High." MD notes reflected the patient ingested prescription and OTC drugs, including sedatives, because they were "having a lot of pain when [sic] to escape the pain but did not care if [they] died. Currently says [they feel] numb when asked if [they are] suicidal." Although an extensive QMHP evaluation was conducted that indicated discharge was appropriate, there was no VPD review documented for the encounter of this individual considered "vulnerable" secondary to behavioral health concerns.

* During interviews with staff that included the EDM, EDO, DON, CEO, the PHSCD CNO and others on 02/01/2024 throughout the day at 1030, 1500, and 1530 staff stated that since the beginning of January actions taken had included: daily monitoring/audits of vulnerable patient

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A 000	Continued From page 9 cases, assessment of ED operations and staffing, expanded social worker hours, changes to triage nurse and CRN hours and roles, additional training, and additional management support. The CEO and the PHSCD CNO expressed commitment to providing safe and appropriate care to all vulnerable patients that presented to the hospital. Documentation of daily monitoring/audits, gaps identified, and actions taken were provided and confirmed. . ********** The following abbreviations, acronyms, and definitions may be used in this report: ACLS - Advanced cardiac life support ALS - Advanced life support AMA - Against medical advice AMR - American Medical Response AVS - After visit summary Bio - Biological BHU - Behavioral Health Unit BIBA - Brought in by ambulance BP - Blood pressure CAPU - Child Adolescent Psychiatric Unit CBD - Cannabidiol CCU - Critical Care Unit CEO - Chief Executive Officer CFR - Code of Federal Regulations CM - Case Manager CMO - Chief Medical Officer CMS - Center for Medicare and Medicaid Services CNO - Chief Nursing Officer CRN - Charge nurse CUS - I'm Concerned, I'm Uncomfortable, this is a Safety issue. CVA - Costovertebral angle DHHS NIH - Department of Health and Human	A 000		

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Services National Institutes of Health
DPSR - Director Patient Safety & Risk
DON - Director of Nursing
ECGs - Electrocardiography
ED IDT - Emergency Department
EDM - Emergency Department Manager
EDO - Executive Director of Operations
EDT - Emergency Department Technician
EHR - Electronic health record
EMC - Emergency medical condition
EMR - Electronic medical record
EMS - Emergency Medical Services
EMTALA - Emergency Medical Treatment and Active Labor Act
ETA - Estimated time of arrival
GCS - Glasgow Coma Scale is a method for assessment of impairment of conscious level in response to defined stimuli that evaluates: Eye opening, Verbal response, and Motor response, with a maximum total of 15 points.
GU - Genitourinary
HI - Homicidal Ideation
HIM - Health information managers
HMC - Hillsboro Medical Center
HS - House/Hospital Supervisor
Hx - History
ICU - Intensive Care Unit
IJ - Immediate Jeopardy
IV - Intravenous
LCSW - Licensed Clinical Social Worker
LEMC UCBH - Legacy Emanuel Medical Center Unity Center for Behavioral Heatlh
LEOs - Law Enforcement Officers
LIP - Licensed Independent Practitioner
LWBS - Left without being seen
L&D - Labor and Delivery Unit
MAR - Medication Administration Record
MBH - Manager of Behavioral Health
MD - Medical Doctor

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MPD - Milwaukie Police Department
MPDOs - Milwaukie Police Department Officers
MSE - Medical screening exam
NAD - No acute distress
NICU - Neonatal Intensive Care Unit
NPO - Nothing by mouth
n/v - Nausea and vomiting
OB/GYN - Obstetrics/Gynecology
OD - Overdose
OTC - Over the counter
PHSCD CNO - Providence Health System Central Division CNO
PIV - Peripheral intravenous line
PMH - Providence Milwaukie Hospital
POC - Plan of care
POH - Police Officer Hold
POV - Private owned vehicle
Pt - Patient
P&Ps - Policies and Procedures
PPMC - Providence Portland Medical Center
PSVMC - Providence St Vincent Medical Center
QMC - Quality Management Coordinator
QMHP - Qualified Mental Health Professional
RN - Registered Nurse
SA - State Agency
SBAR - Situation, Background, Assessment and Recommendation
SI - Suicidal Ideation
SO - Security Officer
SW - Social Worker
Sx - Symptoms
THC - Delta-9 tetrahydrocannabinol
UC - Urgent care
US - Ultrasound
VP - Ventriculoperitoneal
VPD - Vulnerable Patient Discharge
WC - Wheelchair
WR - Waiting room
y.o. - years old

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A2400	COMPLIANCE WITH 489.24 CFR(s): 489.20(l) [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: ********** Based on observation, review of video-recordings, interviews, email communications, review of central log and medical record documentation for 17 of 30 encounters of individuals who presented to the hospital for emergency services (Patients/Encounters 1, 2, 3, 5, 9a, 9b, 16, 17, 19, 21b, 21c, 21d, 21e, 21f, 21g, 22b, and 33), review of incident and internal investigation documentation, review of P&Ps, and review of other documents, it was determined that the hospital failed to fully develop and enforce EMTALA policies and procedures that ensured it met its EMTALA obligations in the following areas: * To post required EMTALA signage in conspicuous places where individuals, patients, and their representative waited for examination and treatment. * To maintain a complete and accurate central log of all individuals who presented to the hospital for emergency services. * To provide adequate MSEs to all individuals who presented for emergency services to determine whether an EMC existed. * To not dissuade individuals from staying at the hospital to receive MSEs, and for those who left prior to an MSE, to obtain or attempt to obtain written and informed refusal of MSE in accordance with its P&Ps. * For those individuals for whom an EMC had not been resolved or ruled out, to affect appropriate transfers to other hospitals for further	A2400		

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A2400	Continued From page 13 examination and stabilizing treatment not within the hospital's capabilities or capacity at the time, that included physician certification of patient specific benefits and risks of transfer, use of appropriate medical transportation with qualified personnel, and provision of medical records. Findings include: 1. Refer to the findings cited under Tag A-2402 related to the posting of EMTALA signage. 2. Refer to the findings cited under Tag A-2405 related to the maintenance of a central log. 3. Refer to the findings cited under Tag A-2406 related to the provision of MSEs. 4. Refer to the findings cited under Tag A-2409 related to the elements of appropriate transfer.	A2400		
A2402	POSTING OF SIGNS CFR(s): 489.20(q) [The provider agrees,] in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information	A2402		

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A2402	Continued From page 14 indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX. This STANDARD is not met as evidenced by: ********** Based on observation, interview and review of policies and procedures, it was determined the hospital failed to enforce EMTALA policies and procedures that ensured the posting of signage, that specified individuals' EMTALA rights with respect to examination and treatment for emergency medical conditions and women in labor, in all areas likely to be noticed and where individuals waited for examination and treatment. Findings include: 1. Review of the P&P titled "Emergency Treatment and Active Labor Act (EMTALA)" dated effective "02/2022" reflected " ... Signage - means the signs posted by the Hospital in its dedicated ED(s), L&D/Perinatal department(s) and in a place or places likely to be noticed by all individuals entering the dedicated ED(s),), (sic) L&D/Perinatal department(s), as well as those individuals waiting for examination and treatment. The signage must inform individual (sic) of their rights under EMTALA. Each Hospital will post signage in the dedicated ED and L&D/Perinatal Department specifying ... the rights of individuals under the law with respect to examination and treatment for emergency medical conditions ... the rights of women who are pregnant and are having contractions ... whether the hospital participates in the Medicaid program ... " 2. During a tour of the ED on 12/20/2023	A2402		

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A2402	Continued From page 15 beginning at 1015 with the EDM and other hospital staff, the following observations were made: * The main ED waiting room did not have any EMTALA signs observed in that waiting area. These observations were confirmed during an interview with the EDM at the time of the observation. The EDM confirmed the goal is that all individuals waiting for exam and treatment would be triaged in one of the three triage rooms, where EMTALA signage is posted. The signage in the three triage rooms was observed.	A2402		
A2405	EMERGENCY ROOM LOG CFR(s): 489.20(r)(3) [The provider agrees,] in the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain a central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. §489.24 The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services. This STANDARD is not met as evidenced by: ********** Based on review of video-recordings, interviews, review of the central log and medical records for 5 of 30 encounters of patients who presented to the hospital for emergency services and were reviewed for the central log (Patient/Encounters 21b, 21c, 21f, 21g, and 22b), and review of P&Ps, it was determined the hospital failed to fully	A2405		

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A2405	Continued From page 16 develop and enforce its EMTALA policies and procedures to ensure maintenance of a central log that contained clear and accurate information about each encounter for all individuals who presented to the hospital for emergency services: * Not all encounters of individuals who presented to the hospital were entered on the log. * The log did not clearly or accurately reflect for each patient the information provided on the log: time of arrival, chief complaint, disposition, and time of disposition. Findings include: 1. The P&P titled "Emergency Medical Treatment and Active Labor Act (EMTALA)" dated as "Last Revised 02/2022" was reviewed. It included the following information: "Central log - is a log maintained by the hospital on each individual who comes to its dedicated ED or L&D/Perinatal Department. Each dedicated ED and L&D/Perinatal Department of the Hospital will maintain a central log recording the names of individuals who present to the department seeking treatment and indicate whether these individuals refuse treatment, were denied treatment, or were treated, admitted, stabilized, and/or transferred or were discharged." 2. The central log for Patient 21b reflected that they presented to the ED on [redacted]2023 at 0340 with a "Chief Complaint" of "[ambulance]." The "ED Disposition" on the log was "Ama" on [redacted]/2023 at 0354. * Regarding the chief complaint, the medical record reflected the patient was BIBA. It was unclear for what reason EMS brought the patient to the hospital. * Refer to Tag A-2406 for the detailed findings of	A2405		

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A2405	Continued From page 17 this encounter. 3. Review of the central log revealed no evidence of Patient 21c's second [redacted]/2023 encounter shown in video recordings that resulted in the patient being brought back into the ED after the first encounter above. The video recordings showed the patient transported by wheelchair back into the ED at 0425 and being transported by SO from the ED toward the bus stop on the street at 0433. * Refer to Tag A-2406 for the detailed findings of this encounter. 4. The central log for Patient 21f reflected that they presented to the ED on [redacted]/2024 at 1404 with a "Chief Complaint" of "Followup Medical Problem." The "ED Disposition" on the log was "Discharge" on [redacted]/2024 at 1644. * Regarding the chief complaint, the medical record reflected the patient was BIBA. It was unclear what "Followup Medical Problem" meant and for what reason EMS brought the patient to the hospital. * Regarding the time of disposition, video recordings reflected that the patient was removed from the ED to the exterior ambulance parking area at 1449, and that SOs transported the patient by wheelchair away from the hospital toward the bus stop on the street at 1518. * Refer to Tag A-2406 for the detailed findings of this encounter. 5. The central log for Patient 21g reflected that they presented to the ED again on [redacted]/2024 at 1644 with a "Chief Complaint" of "Possible Sepsis." The "ED Disposition" on the log was "Transfer to Another Facility" on [redacted]/2024 at 2232.	A2405		

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A2405	Continued From page 18 * Regarding the time of arrival, video recordings reflected that the patient was BIBA and presented to the ED at 1619. * Refer to Tag A-2406 for the detailed findings of this encounter. 6. The central log for Patient 22b reflected that they presented to the ED on [redacted]2023 at 1712 with a "Chief Complaint" of "Mental Health Evaluation; Agitation." The "ED Disposition" on the log was "Discharge" on [redacted]2024 at 1418. * Regarding the disposition, the medical record reflected that the patient was admitted to the PMH inpatient BHU when a bed became available. * During interview at the time of the record review on 01/31/2024 beginning at 1445 the MBH confirmed that the patient was admitted to the hospital as an inpatient.	A2405		
A2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c) (a) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must- (i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who	A2406		

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A2406	Continued From page 19 meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met: (A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period. (B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan. (C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay. (D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.	A2406		

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A2406	Continued From page 20 (E) There has been a determination that a waiver of sanctions is necessary. (ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act. (c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: ********** Based on review of video-recordings, interviews, email communications, review of central log and medical record documentation for 10 of 30 encounters of individuals who presented to the hospital for emergency services who did not receive an adequate MSE or who left the hospital prior to an MSE, including for some patients who had multiple encounters (Patient/Encounters 3, 5, 9a, 9b, 19, 21b, 21c, 21d, 21e, and 21f), review of incident and internal investigation documentation, review of P&Ps, and review of other documentation, it was determined that the hospital failed to fully develop and enforce	A2406		

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A2406	Continued From page 21 EMTALA policies and procedures that ensured that individuals who presented to the hospital for emergency services received an adequate MSE within the hospital's capabilities and capacity to determine whether an EMC existed, or were not dissuaded by hospital staff from staying at the hospital to receive an MSE: * A houseless patient brought to the hospital by ambulance on did not receive an adequate MSE and was discharged to LEOs who had been called to remove them from the hospital for refusal to be discharged. Hospital staff failed to provide further MSE in spite of repeated verbalized concerns by LEOs about the patient's somnolent and unresponsive condition while they were still in the ED and after they had been transported to the LEO car in the parking lot. The patient was driven to a second hospital by LEOs and was found to be unconscious upon arrival. Resuscitation efforts were taken in the second hospital's ambulance bay but were not successful and the patient died. * A houseless patient brought to the hospital by ambulance on multiple occasions during a three-day period and who exhibited behavioral/psychiatric symptoms and worsening physical condition did not receive adequate MSEs that included behavioral health evaluation and was discharged each time to a bus stop. On the sixth visit during those three days the patient's behaviors escalated, they were found to be septic, they required intubation and a ventilator, and they were transferred to another hospital for ICU management. * For other patients who left the hospital without receiving an MSE it was unclear whether hospital staff did or said anything to dissuade them from staying. There was no indication they had been informed of the risks of leaving the hospital	A2406		

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A2406	Continued From page 22 without an MSE, nor that attempts to obtain informed written refusal for a MSE had been made. Based on findings for Patient 19 described below in this Tag, and as stated in Tag A-0000 of this report, on 12/21/2023 the hospital was notified that an IJ situation had been determined to exist. An IJ Removal Plan was approved on 12/22/2023, and the IJ was subsequently removed on 12/28/2023 after verification that the IJ Removal Plan had been implemented. Findings include: 1.a. The P&P titled "Emergency Medical Treatment and Active Labor Act (EMTALA)" dated as "Last Revised 02/2022" was reviewed. It included the following information: * "This policy applies to all patient populations presenting to an ED (including pediatric patients), L&D/Perinatal Department, or anywhere on hospital property with an emergency medical condition needing treatment or transfer to or from any Providence hospital." * An MSE "is an exam completed by qualified medical personnel to determine whether an EMC or active labor exists ... The hospital shall not discriminate against any individual when providing an MSE. A complete and appropriate MSE will be performed on all individuals who come to the hospital requesting examination or treatment or attempts will be made to advise the patient of the risk of leaving before an MSE can be completed. An MSE will be completed regardless of an individual's ability to pay." * "If an individual who is not a hospital patient comes elsewhere on hospital property (hospital property includes the entire main campus, the	A2406		

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A2406	Continued From page 23 parking lots, sidewalks, driveways, and hospital departments/buildings owned by the hospital that are within 250 yards of the hospital) employees will ensure they arrive to the ED where a MSE is offered if: a. The individual requests examination or treatment for an EMC. b. If a prudent layperson observer would believe that the individual is suffering from an emergency condition." * "If a patient presenting to ED(s) or L&D/Perinatal department(s) and while waiting for medical screening decides to leave without examination (AMA/LWBS) the following steps should be taken if possible: a. Explain to the patient it is important to have the medical screening to rule out whether they have a medical condition that needs treatment; and b. Use an interpreter if the patient has limited English proficiency, or use an alternate means of communication; and c. Inform the patient of the risks of not having the medical screening; and d. Ask the patient to sign the AMA form acknowledging they understand the risks of leaving without the medical screening; and e. Document on the medical record the above information and if they refuse to sign the AMA, document that on the record as well." 1.b. The P&P titled "ED Patients leaving AMA, Eloped or LWBS," versions dated as "Last Revised: 02/2021" and "Last Revised: 11/2023," was reviewed. Both versions of the P&P included the following information that was unchanged when last revised:: * "[LWBS]: occurs when a registered patient leaves the ED before or after triage but before a [MSE] is initiated by a [LIP] or other individual qualified to perform an MSE ..." * "LWBS: When a patient leaves and/or decides	A2406		

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A2406	Continued From page 24 to leave prior to an MSE, the circumstance should be documented ... - A reasonable effort should be made to locate the patient. Document specific attempt(s) to locate the patient. Notify security and/or law enforcement of patients who leave before treatment is initiated and for whom it is determined that they might be at risk for harm to self and/or others. Document the notification in the medical record. Consider telephoning the patient at home and/or alerting authorities, if appropriate. - If possible, provide information to the patient on the potential risks and benefits of leaving prior to a MSE and attempt to have patient sign a LWBS/AMA form ..." * "Elopement: occurs when a patient leaves the hospital prior to the completion of care, after an MSE has been initiated." * "Elopement: When a patient leaves following an MSE and prior to the completion of care, the circumstance should be documented. - Reasonable effort should be made to locate the patient. Document attempts to locate patient and outcome of attempts. Notify security and/or law enforcement of patients who leave before treatment is completed and who are determined to be at risk for harm to self and/or others. Document the notification in the medical record. Consider telephoning the patient at home or alerting authorities, if appropriate." * "AMA: When a patient refuses to complete a [MSE] or consent to recommended treatment or transfer, risks and benefits should be discussed and a LWBS/AMA form signed. - The ED Provider should explain to the patient in understandable terms the risks of refusal of treatment or transfer ... the reasons and benefits of treatment or transfer ... and/or alternative	A2406		

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A2406	Continued From page 25 treatments, when applicable. - The nurse or ED Provider should complete the LWBS/AMA form. - The RN should document the patient's condition and circumstances surrounding the refusal of treatment or transfer in the medical record." 1.c. The P&P titled "ED Practice Guideline: Adult Initial Assessment and Reassessments" dated as "Last Revised 11/2023" was reviewed. It included the following direction: "Reassess/monitor for outcomes - - Complete a focused reassessment of the chief complaint upon assuming care of a patient. - Reassess the patient to evaluate response to intervention. This includes assessment for the desired or adverse effect of administered medication(s). - Complete a nursing note, with vital signs at least every 4 hours (and more frequently as appropriate). - Repeat vital signs within 1 hour (and more frequently as appropriate) for any abnormal vital signs on the initial assessment. - Vital signs should be re-evaluated within 15 minutes of admission to ICU/CCU or transfer to another facility. - Repeat discharge assessment (including vital signs) as appropriate for condition. A recheck should occur of abnormal vital signs prior to discharge. Any vital sign that remains abnormal should be reported to the provider to verify appropriateness of patient discharge and documented." 1.d. The P&P titled "The Plan for Provision of Care Providence Milwaukie Hospital" dated as "Last Revised 09/2019" was reviewed. It reflected that the hospital's "Scope of Patient Care	A2406		

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A2406	Continued From page 26 Services" included an inpatient "senior psychiatric unit (SPU)." 1.e. During interview on 01/31/2024 beginning at 0930 the EDM stated that a QMHP was scheduled in the ED from 0800 to 2300 seven days a week, and there were no provisions, including on-call, for QMHP coverage from 2300 to 0800. ********** 2.a. The central log for Patient 19 reflected that they presented to the ED on [redacted]/2023 at 1834 with a "Chief Complaint" of "Wound; Cold Exposure." The "ED Disposition" on the log was "Discharge" on [redacted]2023 at 2144. 2.b The findings that follow for this encounter reflected discrepancies and contradictions in the EHR, inconsistencies between the EHR documentation and video recordings and interviews, and reflected that the hospital did not fulfill its EMTALA obligation for Patient 19. For example: * ED staff decided that Patient 19's worsening condition was purposeful behavior to resist discharge from the ED. * A MSE that included an evaluation of Patient 19's change/worsening condition and the alleged behavioral/psychiatric symptoms was not conducted, instead police were called to remove the patient from the hospital. There was no reassessment of the patient's physical condition, including vital signs and GCS taken only at the time of admission, and there was no behavioral health assessment. * It was unclear whether an unwitnessed and undocumented fall in the ED shower had been evaluated as part of an MSE. * In response to the patient's behaviors Narcan	A2406		

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A2406	Continued From page 27 was administered in the absence of labwork and objective assessment of the patients' condition, including such as drug screening, vital signs, and GCS. * The Narcan was administered ~ 20 minutes before MPDOs transported Patient 19 from the ED into a police vehicle. That was contradictory to Narcan literature that reflected "observation in the emergency room for two to four hours is prudent" for a patient to whom Narcan is administered. Further, the patient's condition was not assessed in accordance with the instructions for post-Narcan assessment. * Patient 19 was transported with wrists handcuffed behind their back into the back seat of a MPD vehicle where they remained for ~ 40 minutes during which time MPDOs returned to the ED and expressed concern about the situation to medical staff, and during which time the hospital's HS went to the parking lot to "assess" the situation but never looked at the patient. When MPDOs made arrangements to take the patient to another hospital's psychiatric unit, they left PMH premises with the patient. * PMH staff failed to respond appropriately to Patient 19's change of condition and MPDO's concerns by letting the patient be removed from the ED, and by not returning the patient to the ED for further examination and stabilizing treatment when further concerns were expressed by MPDOs. 2.c. The medical record for Patient 19's [redacted]2023 ED encounter was reviewed and included the following: * The ED Care Timeline reflected the following chronology of events on [redacted]023: - 1834 "Patient arrived in ED" and "Arrival Complaint" recorded as "[Ambulance]."	A2406		

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A2406	Continued From page 28 - 1841 "Chief Complaints Updated" to "Cold Exposure" and "Wound." - 1841 RN wrote that "Pt states being homeless and feeling cold. Pt has a wound to [their] chin and the back of neck. Pt states being tired and weak and hungry. Pt soiled [themselves] and requires clean up." - 1846 RN recorded the only vital signs in the record as "Vitals Temp: 35.6 °C (96.1 °F) Pulse: 105 Resp: 16 BP: 124/78 SpO2: 93 %" and "Patient Acuity 3." - 1848 RN recorded the only GCS in the record as "Glasgow Coma Scale Best Eye Response: 4-->(E4) spontaneous Best Verbal Response: 5-->(V5) oriented Best Motor Response: 6-->(M6) obeys commands Glasgow Coma Scale Score: 15." - 1905 EDT recorded Patient 19 was moved to ED Room 19. - 1910 MD F was "assigned as Attending [physician]" and "PROVIDER CONTACT INITIATED." - 1938 MD F placed orders for "Nursing - Please feed patient. Please dress right jaw wound Medications - cephalexin (KEFLEX) capsule 500 mg." - 1942 MD F discontinued orders for "cephalexin (KEFLEX) capsule 500 mg." - 1942 MD F recorded "Orders Placed" for "Medications - sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet 1 tablet" and "Discharge Orders Placed" for "Medications - sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet." - 1942 MD F recorded "ED Disposition set to Discharge." - 1951 RN recorded "AVS Printed ED After Visit Summary." - 2000 A "CM/SW Assessment" note only related	A2406		

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A2406	Continued From page 29 to transportation was recorded and included "Planned Discharge Transportation will be provided by: other (comment) (WC Van) ..." - 2002 RN recorded that one tablet of Bactrim DS by mouth was given to the patient. - The next entry was recorded at 2127. - 2127, one hour and 25 minutes later, MD F recorded "Orders Placed Medications - naloxone (NARCAN) 4 mg.nasal spray 4 mg." - 2139 RN recorded "Medication Dispense to Home naloxone (NARCAN) nasal liquid (Prepack) 4 mg - Dose: 4 mg ; Route: Nasal ; Site: Nare-Left ; Scheduled Time: 2130" and "MAR Mini Flowsheet." - 2143 RN wrote "Care Handoff Report given to: (PD called)" and "Pt voluntarily reluctant to leave even with security assistance and multiple redirection tactics deployed. Pt was perfectly pleasant and cooperative until transport arrived and we began to get [them] up to leave. PD will be called to escort pt off of premises." - 2144 RN recorded "Patient discharged." * The Medication Administration record reflected that on [redacted]2023 at 2139 the RN's "Action" taken in response to the physician order for naloxone (NARCAN) was "Dispense to Home." * Flowsheet documentation reflected that on [redacted]2023 at 2143 the RN recorded "Care Handoff Report Given to - PD called." * The following day, on [redacted]2023 at 0940 MD F electronically signed an "ED Provider Note" included the following information: - "Clinical Impression and Plan Final diagnoses: Facial cellulitis Cold exposure, initial encounter Opioid abuse (HCC)" - "ED Prescriptions Sig sulfamethoxazole-trimethoprim (BACTRIM DS)	A2406		

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A2406	Continued From page 30 800-160 mg per tablet Take 1 tablet by mouth 2 times daily for 7 days." - "Follow-up Information Schedule an appointment as soon as possible for a visit with [Internal Medicine MD in Clackamas, Oregon]." - "Method of Arrival: ambulance" - "Patient presents covered in feces with complaints of cold exposure. Patient reports that [they are] homeless, reports that [they have] been cold over the past couple days." - "Diagnostics and Procedures The following tests were ordered and independently interpreted by me: [None recorded] Labs Reviewed - No data to display No orders to display." - "Physical Exam ... Const: Alert, no acute distress, non-toxic appearance. Disheveled appearing however resting comfortable speaking full sentences without distress ... Resp: Lungs clear without wheezes, rales or rhonchi. No increased work of breathing. No chest tenderness. Cardiovasc: Normal rate and regular rhythm. Periphery well perfused. Abd/GI: Soft, non-tender, non-distended. No pulsatile abdominal mass. GU: No CVA tenderness. Skin: Pink, warm, dry. The right mandibular region shows a 3 cm x 4 cm area of erythema with associated induration, no fluctuance or subcutaneous emphysema. No active purulence. Another large area of superficial ulceration over the posterior neck. No active bleeding from either region. No fluctuance or subcutaneous emphysema appreciated. Ext: Atraumatic, grossly normal range of motion. No edema. No palpable venous cords Back: Normal inspection. No tenderness. Neuro: Alert & oriented, speech mildly slurred no	A2406		

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A2406	Continued From page 31 gross focal deficits. GCS 15. Psych: Affect normal. Appropriate attention, cooperation." - "[Pt 19] with a history of fentanyl abuse presents with cold exposure and wound to the right jaw. Patient reports that [they have] been cold over the past couple days. [Pt] reports that [they have] a chronically fractured jaw. [Pt] reports that [they have] a wound on the neck as well as the right jaw region that [they have] been picking at. Patient denies any recent trauma ... denies any worsening pain or redness but [they want] the wounds to be evaluated. [They deny] any difficulty breathing or swallowing ... reports that [they are] hungry and is asking for something to eat ... denies any fevers, recent trauma, or any further associated complaints ... is disheveled/unkempt appearing however resting comfortably speaking full sentences without acute distress ... mildly tachycardic and borderline hypothermic with otherwise stable vital signs and no signs of acute distress. The right mandibular region shows a 3 cm x 4 cm of erythema with associated induration, no fluctuance or subcutaneous emphysema. No active purulence. There is another large area of superficial ulceration over the posterior neck, no active bleeding from either region. No fluctuance or subcutaneous emphysema. Patient is protecting [their] airway ... exam is otherwise unremarkable. Clinical picture consistent with cold exposure. Patient has evidence of a wound on the right jaw as well as the neck that appears to have associated cellulitis. Patient has a normal mental status, is moving all extremities normally without any focal neurological deficits. [They are] protecting [their] airway ... borderline tachycardic with otherwise stable vital signs. No concerns for acute stroke syndrome, sepsis, impending airway	A2406		

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A2406	Continued From page 32	A2406		

compromise, or any other complicating features. During patient's emergency department visit [they were] showered and cleaned ... provided warm close [sic] and blankets. The patient was provided food and snack ... treated with a dose of antibiotics to cover for [their] acute infection, instructed to follow-up closely with outpatient providers. Patient was treated with Medications sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet 1 tablet (1 tablet Oral Given [redacted]23 2002) naloxone (NARCAN) nasal liquid (Prepack) 4 mg (4 mg Nasal Dispense to Home [redacted]23 2139)."
- The note included an entry by MD F that reflected at "2124: Patient was being discharged when [they were] noted by staff to seemingly volitionally fall out of the wheelchair. No traumatic injuries noted. Staff returned [Pt] back to the wheelchair where [they] sat for a brief period of time and then continued to lower [their] legs to the ground. Security attempted to keep [Pt] in the wheelchair and the patient continued to slide out of the wheelchair to the ground. The patient was returned to the bedside where [they continue] resting seemingly comfortably protecting [their] airway, is withdrawing and localizing to pain in all 4 extremities without distress. Patient is alert and tracking with [their] eyes protecting [their] airway however not answering my questions at this time. I see no traumatic injuries, no focal deficits or any signs of distress. I will try a little naloxone and continue to monitor."
- The note included an entry by MD F that reflected at "2150: Naloxone administered. Patient reevaluated. No clinical change. Continues to be alert, breathing comfortably and moving extremities normally. NO signs of significant clinical decompensation, patient is stable for discharge. Patient has history of

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A2406	Continued From page 33 fentanyl abuse and [their] mental status appears to be consistent with mild opioid intoxication (slurring speech, pinpoint pupils). [Pt] is oxygenating normally on room air without focal deficits. I do not think [Pt] warrants more doses of naloxone at this time. Police were summoned by staff due to patient's inability to be transported in wheelchair. Screening medical examination performed, no emergent medical condition identified." 2.d. Patient 19's [redacted] 2023 encounter was captured on hospital video recordings (without audio capability) from multiple interior and exterior camera views. Those were reviewed with the EDM, CMO, DPSR, and QMC. It was noted for this Patient 19 encounter that timestamps on exterior and interior cameras did not always align and may have resulted in timestamp discrepancies of a minute or two between interior and exterior views. The video recordings showed the following: * 1826 Ambulance arrived and EMS transported Patient 19, who was awake and had head elevated on a gurney, into the ED through the ambulance entry. * 1832 In the ED WR/lobby near the triage rooms EMS staff removed the blanket and unbuckled Patient 19 who was on the gurney. Patient 19 independently swiveled themselves to dangle legs off the gurney, stood up and walked without assist into TR3. EMS left the WR/lobby with the gurney. * 1901 Patient 19 was pushed by an EDT in an ED corridor and around a corner towards Room 19. * The 1901 image was the last time Patient 19 was shown on video recordings unit ~ 2120. * 2120 Patient 19 pushed around corner from	A2406		

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A2406	Continued From page 34 treatment room into ED corridor in a Stryker transport chair by a "Ride to Care" transport person, and was followed by a SO and RN. The patient was restrained around the waist, their head was slumped to the left, and they were positioned so that their back was partially on the chair seat as if they had slid down from a seated position. The SO and the RN attempted to pull the patient up in the chair. However, the patient's limp body slid further down so that their back was nearly entirely on the chair seat, their buttocks was off the chair seat, and their legs stretched out in front of the chair. The restraint was then positioned up on their chest under their arms. The patient made no purposeful movements and did not appear to be awake or alert. * 2121 The HS and MD F approached the scene in the corridor, observed the patient, and conversed with staff. * 2122 There was no attempt to reposition the patient and the transport chair was pulled backwards and moved back around the corner of the corridor towards the ED treatment room while the patient partially laid on the chair seat and legs were extended and dragged on the floor. * 2154 Five MPDOs entered the ED through the ambulance entry and proceeded through the ED towards down corridor towards the ED treatment room where Patient 19 was located. * 2209 MPDOs pushed the patient around the corner from the ED treatment room in a Stryker transport chair. There was a restraint in place around the patient's waist and the patient's hands were handcuffed behind their back. The patient's head and upper body were slumped to the right and their lower legs and feet were dragged on the ground under the chair as the chair was pushed forward. An MPDO attempted to position the patient's legs/feet on the chair's foot rests but the	A2406		

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A2406	Continued From page 35 patient appeared to not have control of their lower extremities. * 2212 Patient was shown being pushed in the transport chair from the hospital into the parking lot where multiple MPD vehicles were parked. The patient was slumped over in the chair. Although the nighttime parking lot video was grainy and dark, the officer's were seen to transfer the patient into the back seat of one of the police vehicles. Some MPDO's returned towards the hospital and four or five MPDO's remained in the parking lot near the vehicles. * 2225 Three MPDOs reentered the ED through ambulance entry doors and proceeded down a corridor where they stopped and interacted with staff. MD H joined the interaction then walked towards the ambulance entry/exit after two of the officers. A conversation between the officers and MD H occurred just inside the ambulance entry. * 2226 The officers and MD H walked out of the ED. MD H stopped just a step or two outside of the hospital at the doorway while the officers continued away from the hospital. MD H walked a few steps back into the ED, then turned around and walked back outside of the hospital and out towards the parking lot out of camera view. * 2227 Forty seconds after MD H walked out of the ED, MD H reentered the ED through the ambulance entry. * 2229 Two MPDOs entered the ED through ambulance entry doors and walked down corridor. * 2232 Two MPDOs exited the ED through the ambulance entry doors. * 2233 MD H walked down same corridor towards ambulance entry doors and exited to the sidewalk, then promptly turned around and returned into the ED and back down a corridor. * 2236 HS exited ED through ambulance entry	A2406		

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A2406	Continued From page 36	A2406		

doors and walked into the parking lot near the vehicle that Patient 19 was placed in. The HS appeared to talk to MPDO's but did not approach the vehicle the patient was in.
* 2241 HS walked towards the police vehicle the patient was in but did not get closer than a few feet away, then walked from the parking lot back into the ED.
* 2250 The MPD vehicle the patient was in drove out of the hospital's parking lot towards the street.

2.e. The current City of Milwaukie Police website page titled "Body Worn Camera Footage Released to Pending Open Records Requests" contained the following link to Body Worn Camera footage of 1 hour and 49 minutes worn by one MPDO from time of MPDO arrival at PMH through the time of arrival at the second hospital the patient was transported to:
https://www.y[redacted] The footage had audio, some of which was redacted. It was also redacted to cover the faces of PMH staff and other patients. It included the following excerpts and some of the times may be approximate:
* 2157 MPDOs arrived to ED Room 19 where the patient was observed with HOB slightly raised, head slumped to the left, eyes closed, face gaunt, emaciated, bones prominent on right leg mid-thigh to mid-calf area that was not covered by pant leg and sock, minimal body movement, erratic and jerky leg movements, left leg slipped down between mattress and raised siderail, minimally responsive to PMH staff and MPDOs, making moaning and guttural sounds only.
* 2158 Hospital staff heard to say the patient "was a little more tired than [they were] previously." MPDOs attempted to converse with patient who did not respond and remained limp and lethargic

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A2406	Continued From page 37 with periodic jerky extremity movements. * 2208 MPDOs transferred patient to transport chair. No PMH staff were present to assist with the transfer. The patient required two person full assist from MPDOs as their body remained limp and lethargic. The patient was handcuffed with their hands behind their back. * 2210 MPDOs pushed patient from treatment room down hallway to exit. Patient remained non-responsive, body slumped to the right, and legs/feet were periodically repositioned by MPDOs as they slid off the footrests. Hospital staff did not assist with the transport through the ED or positioning of the patient during that transport. * 2213 MPDO pushed transport chair through parking lot to the police car. The patient's left foot was off the footrest and dragged on the ground. An MPDO stated to another "Do you at all feel comfortable with anything that is going on right now?" The reply was "No." Then one said, "Who is somebody we could call to probably help with guidance?" They decided to call the on-duty Sergeant. * 2215 Patient was slumped over in chair in parking lot. MPDOs are heard to state that the patient "won't stand, talk ..." and the patient was "not in any condition to be released." * 2218 MPDO stated "No way [the patient] is even coherent enough to receive citation now." * 2223 Patient transferred with full assist into back seat of police car. They are slumped over and seat belted. * 2228 MPDO reentered hospital and asked for the "discharge papers." Approached a staff person and said, "Do you think [the patient's] just full of it, [faking it]?" The staff person responded that the patient "was not like that at all then literally right as the [earlier planned transport to a	A2406		

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A2406	Continued From page 38 shelter] showed up and we said your ride is here ... the patient was against everything." * 2234 MPDO returned to the police car. An MPDO stated "What's the reason for taking [the patient to Unity]? [The patient] doesn't say [they're] gonna kill [themselves] or hurt anybody right? In fact [they haven't said anything, [they're] just drooling on [themselves] involuntarily ..." * 2236 The patient was seen through rear passenger door of the police vehicle to be slumped over with head on chest. * 2238 MPDO heard in radio contact with someone and stated "we're doing a POH on this subject." * 2247 An MPDO called the patient's name and another officer responded that the patient was "not responsive." * 2250 The MPDO car with the patient inside drove away off hospital premises. * 2305 MPDO drove into the LEMC UCBH ambulance bay. * 2306 MPDOs waited for staff to present to the ambulance bay. One looked into the back seat window and stated to the other "do you see [the patient's] chest rising? " * 2308 MPDOs opened car door and one stated they didn't know if the patient had a pulse. The MPDOs transferred the patient from the car to the ambulance bay floor, removed the handcuffs and started CPR. 2.f. During interview with staff that included the EDM, CMO, DPSR, and QMC on 12/19/2023 at 1515 they stated that the hospital had started its investigation and was still in process, they had identified some preliminary areas to address related to complex patient safety and decision making issues, but had not implemented any changes at the time of this survey.	A2406		

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A2406	Continued From page 39 2.g. During surveyor interview with MD F on 12/20/2023 at 1600 they confirmed they were Patient 19's physician on [redacted]2023 and provided the following information: * MD F saw Patient 19 for the first time when the patient was in ED treatment room 19. The MD had been told by staff that the patient had a "minor fall" with no report of injuries since they'd been in the ED. * The patient was "awake, alert, chronically unhealthy, and had not signs of distress or acute issues." * They "provided an MSE" that consisted of a discussion of the patient's wounds and history, and the MD "examined the patient." MD F determined the wounds could be infected so ordered antibiotics and assessed no indications for further workup or interventions. MD F determined that patient was "ok to discharge." * They did consider labs and other diagnostic testing but "didn't see" any signs of sepsis, distress, or other clinical necessity for lab orders. * The reported fall "didn't have any relevance to the patient's ED clinical course." * Regarding the decision to discharge MD F stated that there were "no emergency needs that would require reassessment." They stated that the "social worker" indicated they were able to get the patient to a shelter. They stated that "no one brought any concerns to indicate that that wasn't a good plan." * Regarding the 85 minute gap in the medical record between 2002 and 2127 the MD stated the "I had moved on to other patients ... I was aware that the patient was waiting to discharge ... patient waiting for transport to shelter ... no one reported any issues." * "Next thing" the RN reported that when they	A2406		

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A2406	Continued From page 40 were trying to discharge the patient the patient had a "change of condition" and that the patient was purposefully dragging their legs and feet to prevent the wheelchair from being pushed forward. * MD F proceeded to the hallway where the patient was located to assess the behavior being described and witnessed staff physically picked up the patient's legs and placed them on the foot rest. The patient was "alert, eyes open, made eye contact with me ... when the wheelchair was pushed forward the patient seemingly intentionally placed feet off of the footrest to the ground ... patient made eye contact but no verbal interactions ... a behavioral change was noted and I directed them to take patient back to the treatment room ... back in room 19 I reassessed patient ... they were awake, alert, tracking, moving extremities ... they were in no distress but were notanswering questions ... I had no idea what was the change in patient's behaviors ... could have been possible reaction to previous Fentanyl use ... there was no medical reason to admit ... I wondered if Narcan would change behaviors ... the goal for Narcan administration was to see if that made any changes in patient's status ... I saw patient in room before and after Narcan administration ... I expected staff to conduct discharge activities and steps, including vital signs, and report any changes ... that did not happen ..." * Specifically regarding the Narcan order and administration MD F stated that it was not an "emergent use" because of hypoxia present. They stated that was "not the case for this patient" rather it was administered due to the behavior change for the patient who had a history of opioid use. MD F stated they did not expect that the patient was hypoxic, but the Narcan was	A2406		

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A2406	Continued From page 41	A2406		

administered for a "behavioral concern."
* "I witnessed behaviors and agreed [Patient 19] was resisting. I reassessed the patient and found no issues and said the patient could be discharged."
* Regarding MPD involvement MD F stated the patient was "medically cleared" and staff were attempting to discharge the patient. "If patients are not cooperating or have behaviors resistive to discharge staff will work with SOs to discharge. It the behaviors continue MPD is called." MD F stated they "can't remember who recommended that" course of action.
* They talked with MPDOs outside of the patient's treatment room, introduced themselves, gave a little report, and thanked them. The MD stated they had no further contact or communications with the MPDOs.
* They talked to MD H later who said MPDOs were going to bring the patient back into Room 19, although MD F was confused about this at the time. MD F stated they conferred with the RN, the CRN, and the HS about whether that was happening. MD F asked the HS to go outside and assess and find out what was going on.
* The HS returned to the ED and reported to MD F that MPDOs stated the were going to take the patient to LEMC UCBH. MD F said "I don't know if the HS saw the patient."
* "Never had anyone explicitly asked for [the patient] to be reassessed or expressed concern about [the patient's] condition".
* They "did not consider a QMHP evaluation for psychiatric needs."
* They didn't recall any EMTALA training for the past two to three years, and stated they are "facilitating transfers all the time."

2.h. Review of PMH internal investigation

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A2406	Continued From page 42 documentation reflected a PMH interview with MD F conducted on [redacted]2023. The information included: "I was contacted by the [RN] that [the patient] was intentionally forcing [their] legs out of the wheelchair in an attempt to not move the wheelchair further. The patient was awake and alert and tracking. The patient with no other neuro changes other than not answering questions no other acute changes noted. Ordered Narcan because of patient's hx and to see if there was a change in mental status, it was an attempt to see if there was an opioid component to [the patient's] change. I did multiple reassessments with no concerning mental status changes, no further decompensation." 2.i. During surveyor interview with MD H on 12/20/2023 at 1345 they confirmed they were on duty during Patient 19's [redacted]2023 encounter and stated they had not been Patient 19's ED physician. They provided the following information: * The only time they had seen the patient was when MPDOs wheeled past with "someone" who had their eyes open and sat upright. * They had overheard some communications at the nurses' station about a patient's change of condition after the patient heard they were going to be discharged. * Later MD H was in the corridor outside of an ED Room when two or three MPDO's approached MD H. The MPDO's began to address MD H directly and stated they had second thoughts and concerns about talking Patient 19 into custody and they didn't have a good place for the patient. MD H stated they couldn't recall the exact words MPDO's used but their wish to bring the patient back in was "clearly implied." * MD H stated they did not tell MPDO's to bring	A2406		

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A2406	Continued From page 43 Patient 19 back into the ED. * MPDO's "tone changed" during the interaction. MD H stated the an MPDO stated "If [the patient's] left at the bus stop and [they] freeze tonight that's on you" and the officer "made a point to call out my name." * They told MD F that MPDO's talked about bringing the patient back into the ED. * It was their understanding that HS went outside the hospital to check what the MPDO's concerns were. * They did not recall receiving any EMTALA training over the past two years. 2.j. Review of PMH internal investigation documentation reflected a PMH interview with MD H conducted on [redacted]/2023. The information included regarding the "contact with the Milwaukie PD ... 2-3 of the officers entered through the ambulance bay. They said that they had concerns taking the patient because they didn't know where to take [them]. I only know what I had heard that [the patient] had already been evaluated ... I said to them that [the patient] had been evaluated and I wasn't sure what the issue was ... the police said that they wanted to bring [the patient] back in and I said 'Well [the patient] had been evaluated and I wasn't sure what had changed although I didn't know the details of that evaluation ... I followed them to the doors and one of them said again if [the patient] freezes again at the bus stop it will be on you ... I was concerned that they would take my statements as a refusal. I went back and told [MD F] and [HS] ... that the police had a concern with patient discharging ... I suggested that someone go out to check on the patient ... I also made the statement that if they suggested to check [the patient] back in to triage that we needed to see	A2406		

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A2406	Continued From page 44 that patient." 2.k. During surveyor interview with Patient 19's RN on 12/20/2023 at 1500 they confirmed they were assigned as Patient 19's nurse on [redacted]/2023 and provided the following information: * It was their "first time taking care a homeless patient." * The first time they saw Patient 19 was when the patient was in the ED shower. The observation was for a moment and there was no verbal interaction. The patient was left to shower independently. * A few minutes later staff heard a "thump" and discovered the patient on the floor in the shower laying on their left side. The RN stated they looked for any trauma and asked the patient if they had hurt anything. The patient said "no." The RN stated the patient's affect was "apathetic. The patient sat up and the RN performed wound care to an area on the chin that was "not deep." * They did not take vital signs after the fall or at anytime during the rest of the patient's encounter. * "As soon as the patient was cleaned up MD F looked at [them]" and said they would discharge the patient with Bactrim. * After the RN told the patient they were going to discharge them the patient started resisting discharge by slumping over and dragging their legs as they were being pushed in the chair down the hall. * MD F saw the patient in the hall and said they were "being voluntarily reluctant," that this was behavioral, there was clearly no medical issue, and directed staff to call the police to remove the patient. * The patient was moved back into the treatment room and the MD F did not go into see the patient	A2406		

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A2406	Continued From page 45 until the MPDOs got there. * After the patient was back in the room the RN went out to the nurse's station. MD F approached them and said "we're giving [the patient] Narcan ... wait to call the police until after [the patient] gets the Narcan." * The RN gave the patient a dose of Narcan in the patient's left nostril. "I told the patient I was going to give it ... [the patient] was not unconscious ... was in a bed ... eyes were moving ... motor skills not as active as normal ..." * They didn't see any signs of opioid overdose and MD F said the patient was "medically cleared." * "We call the police when anyone is reluctant to leave ... that seems to be what we do." * The RN determined that Patient 19's "reluctance to leave" was based on their "very purposeful, resistiveness to mobility in the wheelchair with [their] feet, and slumping over." The RN stated the patient never said or verbalized any refusal to leave. 2.I. During surveyor interview with HS RN on 12/20/2023 at 1740 about Patient 19's [redacted]2023 encounter they provided the following information: * They were notified at the time of Patient 19's intended discharge that the patient was "refusing" to be discharged. * As they approached the location of the patient in the corridor they heard MD F say that the patient was "doing this volitionally ... [the patient] was just fine until we said we would discharge [them]" and now the patient would not sit up in the wheelchair and not respond to questions. * The patient was taken back to the treatment room. Their eyes were closed and they were "sliding out of the wheelchair. They weren't "limp"	A2406		

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A2406	Continued From page 46 or "slumped." They did stand to transfer to the bed. They were breathing normally, their color was ok, and there was "nothing to indicate distress" and "nothing about the patient's presentation alarmed me. The patient couldn't be discharged to the shelter at that time with their condition. * HS agreed with staff that the patient's behaviors were "on purpose" to avoid being discharged. * MD F asked the HS to go speak with MPDOs in the parking lot because of MPDO's "negative interaction" with MD H. The HS stated that MD F did not ask them to evaluate the patient. * The HS stated that MPDOs reported they were "not happy to take the patient" who was drooling on themselves and was someone who could not take care of themselves in the "state they are in." * MPDOs stated the jail refused to take the patient. They had decided to place the patient on a police hold and take them to LEMC UCBH. * MPDOs did not ask to check the patient back into the ED. * The HS stated they did not see the patient, did not lay eyes on the patient, and that MPDOs never asked them to. * MPDOs asked if patient could stay in WR/lobby and HS told them that was not a good option. * The HS confirmed they had not documented any of their interactions in the patient's record or elsewhere, as their role was to "facilitate process." 2.m. Review of PMH internal investigation documentation reflected a PMH interview with HS RN conducted on [redacted]/2023. The information included: * "MD F asked me to go out and see what the police officers are doing and so I did ... I did not observe the patient [they] were in the officer's	A2406		

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A2406	Continued From page 47 care. The police said: 'Ya, you know we are concerned about the liability this patient does not look like [they] can take care of [themselves]. [HS] said, our doctors have evaluated [the patient] and said that [they are] back to [their] baseline. [Police said] Well, if we drop [the patient] off somewhere and [the patient] freezes to death ... [they're] drooling on [themselves], and [they don't] seem like [they] can take care of [themselves].'" * During the PMH interview the HS was asked ""Just to clarify, did you advise [the police] that we are able to perform mental health assessments." The HS responded "They never asked for the patient to be evaluated or reevaluated and I did not suggest for them to bring [the patient] back." 2.n. Current hospital and professional organization literature about naloxone (Narcan) was reviewed: * The "Naloxone [Nasal Liquid: Restricted] (Providence Acute Care Formulary)" document "Last Updated 11/20/23" was reviewed. It included the following information: - "Opioid reversal, life-threatening overdose: Note: Patient selection: For patients without normal breathing but with a pulse (as assessed by a health care provider), the [AHA] recommends naloxone administration. For patients without normal breathing and without a pulse (as assessed by a health care provider), the AHA recommends initiation of CPR, the use of an automated external defibrillator, and consideration of naloxone administration." - Side effects included: "High or low blood pressure like very bad headache or dizziness, passing out, or change in eyesight - Seizures - Shortness of breath - Chest pain or pressure, a fast heartbeat, or an abnormal heartbeat - A	A2406		

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A2406	Continued From page 48	A2406		

burning, numbness, or tingling feeling that is not normal - Mood changes - Hallucinations ... - Signs of an allergic reaction, like rash; hives; itching; red, swollen, blistered, or peeling skin with or without fever; wheezing; tightness in the chest or throat; trouble breathing, swallowing, or talking; unusual hoarseness; or swelling of the mouth, face, lips, tongue, or throat."
- "Monitoring Parameters: Respiratory status (oxygenation and ventilation), level of consciousness, heart rate, blood pressure, temperature, signs or symptoms of opioid withdrawal."
- "Nursing Physical Assessment/Monitoring: Monitor for signs and symptoms of acute withdrawal in opioid-dependent patients (pain, tachycardia, hypertension, fever; sweating, abdominal cramps, diarrhea, nausea, vomiting, agitation, and irritability). Monitor for symptoms of acute withdrawal in opioid-dependent patients (pain, tachycardia, hypertension, fever; sweating, abdominal cramps, diarrhea, nausea, vomiting, agitation, and irritability). Monitor signs and symptoms of cardiovascular instability (ventricular fibrillation) following abrupt reversal of opioid antagonists."

* The current Federal DHHS NIH National Library of Medicine article titled "Naloxone" with "Last Update: April, 29, 2023" included the following information:
- "Naloxone is indicated for the treatment of opioid toxicity, specifically to reverse respiratory depression from opioid use."
- "Naloxone has few side effects. The most common are those of acute withdrawal from opioids, such as anxiety, aggression, nausea, vomiting, diarrhea, abdominal pain, and rhinorrhea. In rare cases, the use of naloxone

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A2406	Continued From page 49	A2406		

can precipitate noncardiogenic pulmonary edema. The incidence of naloxone-induced noncardiogenic pulmonary edema is estimated to be between 0.2% and 3.6% of patients who have received naloxone and are transported to the emergency department. Symptoms include persistent hypoxia, despite the resolution of respiratory depression secondary to acute overdose. Patients may also have a cough productive of the classic 'pink, frothy sputum,' indicative of pulmonary edema. Chest radiography will be consistent with the findings of pulmonary edema. It bears mention that the onset of noncardiogenic pulmonary edema occurs within 4 hours in most patients. However, there have been case reports of delayed onset of up to 8 hours after naloxone administration."
- "Patients who overdose on opioids can have not only respiratory depression but also hypotension. These patients should be resuscitated like any other patient and monitored. Additionally, naloxone administration also can trigger an acute withdrawal syndrome, which can present with the following symptoms:
Nausea - Diaphoresis - Vomiting - Tachycardia - Cardiac Arrest."
- "In chronic opioid users, naloxone requires slow administration to individuals who are dependent on opioids. All patients who have responded to naloxone should be continuously monitored for at least six to 12 hours since some opioids (methadone, fentanyl, buprenorphine) have a much longer half-life than naloxone. The half-life of naloxone in adults varies from 30 to 80 minutes. The patient should have vital signs, including pulse oximetry, monitored until obtaining a full recovery. Even after reversing respiratory depression, the patient must be monitored for at least six to 12 hours because the patient may

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A2406	Continued From page 50 have ingested the longer-acting opioids, which will continue to exert their effects after excretion of the naloxone. Any patient that requires IV naloxone doses of more than 5 mg should be admitted." - "For those who completely reverse with 0.4 to 2 mg of naloxone, observation in the emergency room for two to four hours is prudent. If the patient is stable, then discharge is recommended. In general, patients considered for discharge after reversal of the opioid overdose with naloxone should: Be fully mentally alert with a Glasgow coma scale of 15. Not require further dosing of naloxone in the emergency. Have an oxygen saturation of at least 92% on room air. Have a respiration rate of no less than ten breaths per minute. Have a pulse rate of no less than 50 or no more than 120 beats per minute. Have a blood pressure between 110/90 to 140/90 mmHg. Be able to tolerate clear liquids, ambulate, and have no withdrawal symptoms. Have someone drive the patient home and monitor the patient for the next 12 to 24 hours." ********** 3.a. The central log for Patient 21b reflected that they presented to the ED on [redacted]/2023 at 0340 with a "Chief Complaint" of "[ambulance]." The "ED Disposition" on the log was "Ama" on [redacted]2023 at 0354. . 3.b The findings that follow for this encounter reflected discrepancies or contradictions in the EHR, inconsistencies between the EHR	A2406		

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A2406	Continued From page 51 documentation and video recordings and interviews, and reflected that the hospital did not fulfill its EMTALA obligation for Patient 21b. For example: * A MSE that included an evaluation of the behavioral/psychiatric symptoms the patient was brought to the ED for was not conducted. * Inside the ED the patient was never removed from the EMS gurney, and EMS was instructed by hospital staff to remove the patient from the ED. * It was unclear how it was determined that this patient who exhibited behavioral/psychiatric symptoms had the capacity to participate in the AMA informed consent discussion that was documented in the EHR. * A "Vulnerable Patient Discharge (VPD) Safety Review" was not initiated in accordance with the IJ Removal Plan for this patient who was houseless and who demonstrated behavioral/psychiatric symptoms. During interview with the EDM on 01/31/2024 at ~ 1130 they confirmed that a VPD review form had not been completed for this encounter. 3.c. The medical record for Patient 21b's [redacted]2023 ED encounter was reviewed and included the following information: * An AMR ambulance report reflected that on [redacted]2023 at 0312 EMS was dispatched for Patient 21b who was "found to be laying on train tracks by a passer by, when approached the pt claimed [they were] having chest pain and having a heart attack and needed to go to the hospital so the passer by called 911. Upon arrival of [CCFDU] pt began being uncooperative and verbally hostile. MPD was requested by [CCFDU]. For the duration of the call the pt was talking almost non stop in a stream of consciousness kind of way and in no visible distress. Pt made	A2406		

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A2406	Continued From page 52 many statements about how [they] hated all [opposite gender persons] and did not want to answer questions or be touched. [AMR arrived] to find pt seated in a chair in front of a tavern in the care of [CCFDU] and MPD. Got report ... Pt being belligerent and not letting [CCFDU] assess [them] and yelling at MPD. Made contact with the pt offered to take [them] to the hospital, and eventually [they] transferred [themselves] from the chair to the gurney. Moved to ambulance and loaded. Initiated transport and got cursed at the entire ride to the hospital. Pt remained stable and did not try to strike out during the call. Unloaded gurney moved into ED, gave report to triage nurse, nurse addressed pt. Pt told triage nurse [they] did not want to be evaluated. Nurse instructed us to take [Patient 21] outside and let [them] loose. Moved gurney to outside near a bench and pt was assisted from the gurney to the bench cursing all the while. Primary impression: Behavioral/Psychiatric - Psychotic Episode ... Primary Symptom: Abnormal behavior ... Chief Complaint Category: Chest Pain. Factors Impacting Care: Uncooperative, Other, and Psychologically Impaired." EMS arrived at PMH, one mile from the scene, at 0338. * The ED Care Timeline reflected the following chronology of events on [redacted]/2023 for this encounter: - 0340 "Patient arrived in ED ... Arrival Complaint [ambulance] ... ED Information Exchange Resulted Abnormal Result ..." were recorded. - 0347 DO K recorded "ED Disposition set to AMA." - 0348 DO K recorded "Provider Contact Initiated" and wrote "[Patient 21] has made the decision to leave the current treatment against the advice of me. [Patient] has been informed and understands	A2406		

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A2406	Continued From page 53 the inherent risks, including death. [Patient] has decided to accept the responsibility for [their] decision. [Patient] and all necessary parties have been advised that [patient] may return during any business hours for further evaluation or treatment. [Their] condition at time of discharge was at [their] apparent baseline. [Patient] had current vital signs as follows: LMP [sic] [redacted] [sic]." - 0349 RN wrote "Pt arrives with EMS after being called by bystander for [person] down by tracks. Upon arrival pt doesn't want to give name. Pt states I don't want to be seen here. Upon quick review of [Patient's] chart I see [they were] just seen and left AMA from OHSU yesterday. Pt is at baseline according to chart and previous encounters with this writer. Pt refused for MD evaluation and left out the back door with EMS. MD present and aware." - 0354 RN recorded "Patient dismissed." * The Medical record included: "Other Orders ... EDIE ED INFORMATION EXCHANGE ... (Abnormal) ... 3+ ED Locations in 90 Days 5+ ED Visits in 12 Months ... ED Care Guidelines from Tri-County 911 Last Updated: 8/24/23 1:04 PM Care Recommendation: - Client Care Team Currently working to schedule assessment for referral to a higher level of care. - Please speak with the [client] to identify where [they are] staying within the community and if [they] would like a referral to housing/supportive housing. - During business hours please make an attempt to connect the [client] with Aging [sic] Case Manager [Name] to check in and identify next steps for assessment.? - Please make an attempt to complete a mental status exam	A2406		

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A2406	Continued From page 54 - Please make an attempt to complete an up to date mental health assessment. Current Providers: [Name, credential], LCSW, Tri-County 911, Monday through Thursday 5am-3pm. [Phone number]. [Name] Aging/Disability Services Milwaukie Branch, [Phone number]. [Name] Clackamas County ICC, Monday through Thursday Business Hours, [Phone number] ..." The EDIE information reflected the patient had a total of 113 ED visits in the past 12 months in 11 Portland Metro area hospitals. Visits were for a myriad of complaints, including psychiatric and behavioral. The information reflected that patient had a total of 10 inpatient visits in the past 12 months in six Portland Metro area hospitals, those included four psychiatric hospitalizations. * On [redacted]2024 at 1036 DO K electronically signed the final version of their "ED Provider Note" that included the following information: "No chief complaint on file. The pt was triaged to Room [no room number recorded] and the nursing notes were reviewed ... [Patient 21] brought in by ambulance as bystander found patient at bus top [sic] and called 911. Patient does not want to be here, is demanding to leave, stating EMS took [them] against [their] will. This is a patient the staff is familiar with and states [patient] is at [their] baseline. [Patient] is denying medical complaints and refusing exam. Patient has intentional movements but does not provide any useful history or linear story ... yells expletives at staff. Chart review reveals nearly daily contact with emergency department end of this month alone. Patient's behavior today appears consistent with [their] baseline behavior	A2406		

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A2406	Continued From page 55 and mentation. Patient has a history of Chronic heart failure, coronary artery disease, severe protein calorie malnutrition, bipolar, cannabis use, alcohol abuse, heroin abuse, homelessness, benzodiazepine dependence. Patient has the following medications prescribed: Trazodone, tramadol, Depakote, Ability, Cymbalta. The patient's physical exam was remarkable for chronically ill appearing [person] in no acute distress ... has a small excoriation to ring finger with mild bleeding, patient refuses bandaid. Multiple diagnoses were considered including, but not limited to laceration, AMS, schizophrenia, cold exposure. Based on the above data, I felt that the patient's clinical picture was most consistent with laceration not requiring repair. [Patient] refuses any care here. Per chart review [patient] appears to be at [their] baseline and does not require acute interventions. After considering the risks and benefits of inpatient versus outpatient treatment, I felt that patient is stable for discharge. Risks and benefits of treatment plan was discussed with the patient prior to disposition. Impression: 1. Laceration of right ring finger without damage to nail, foreign body presence unspecified, initial encounter ... Procedures [None listed]." * Medical record documentation also reflected: - "Labs ... No documentation. Imaging ... No documentation. Procedures ... No documentation." - "Patient Education ... No documentation. Patient Instructions ... No documentation. After Visit Summary ... No documentation." 3.d. Patient 21b's [redacted]/2023 encounter was captured on hospital video recordings (without audio capability) from multiple interior and	A2406		

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A2406	Continued From page 56 exterior camera views. Those were reviewed on 01/31/2024 with staff that included the EDM. It was noted for this Patient 21 encounter and the other encounters that follow in this report, that timestamps on exterior and interior cameras did not always align and may have resulted in timestamp discrepancies of a minute or two between interior and exterior views. The video recordings showed the following: * 0340 EMS transported patient on gurney through the ambulance entry and into ED hallway near nurse's station. RNs approached and verbally interacted with EMS and patient. No physical contact with patient was made or attempted. * 0343 DO K approached and verbally interacted with EMS and patient while patient remained on the gurney. No physical contact was made or attempted. * 0344 DO K walked away down a corridor. * 0347 EMS transported patient on the gurney and exited the hospital. * 0349 Patient 21 transferred with assistance by EMS from gurney to a bench outside of hospital's ED entrance and EMS walked back towards the ambulance entry. ********** 4.a. The findings that follow for Patient 21's next encounter described under this finding reflected that the hospital did not fulfill its EMTALA obligation for Patient 21c. For example: * The encounter was not entered onto the log. * A medical record was not generated. * It was unclear to what extent an MSE was conducted. * A "Vulnerable Patient Discharge (VPD) Safety Review" was not initiated in accordance with the IJ Removal Plan for this patient who was	A2406		

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A2406	Continued From page 57 houseless. During interview with the EDM on 01/31/2024 at ~ 1130 they confirmed that a VPD review form had not been completed for this encounter. 4.b. Hospital video recordings (without audio capability) captured a subsequent ED encounter for Patient 21c on [redacted]2023, after Patient 21's previous encounter described in Finding 3 above. During the review the EDM stated they were unaware of this encounter that showed the following: * 0352 SO approached patient who was sitting outside the ED entrance on a bench and verbally interacted. * 0356 SO returned to the hospital. * 0357 SO reapproached patient with a wheelchair and verbally interacted. * 0400 SO returned the wheelchair to the hospital. * 0409 HS, accompanied by a SO, approached patient who remained sitting outside the ED on a bench and verbally interacted. * 0415 Second SO arrived to the bench and the HS returned to the hospital. * 0417 Two SOs returned to the hospital. * 0419 DO K and the HS approached the bench and verbally interacted with the patient. The HS returned to hospital and shortly after returned to the bench outside with a wheelchair. * 0425 After two SOs joined DO K, and HS, and the patient transferred into a wheelchair, the group entered the hospital through the ED entrance with Patient 21 who was transported in a wheelchair. * 0426 Group walks through the ED WR/lobby and into the corridor that led into the ED. * 0431 HS and two SOs exited through the door of Triage Room 2 into the WR/lobby and the SOs exited the hospital through the ED entrance with	A2406		

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A2406	Continued From page 58 the patient who was transported in a wheelchair. * 0433 SOs pushed the wheelchair with the patient away from the hospital, down the slight hill that leads to the hospital, towards the main street where a TriMet bus stop was located. 4.c. Review of the central log revealed no evidence of Patient 21c's encounter shown in the video recording that began at 0352. The log reflected only one visit for the patient on [redacted]2023 described under Finding 3 above that had ended with a disposition of "Ama" on [redacted]2023 at 0354. 4.d. A medical record had not been generated for Patient 21c's encounter shown in the video recording that began at 0352. The medical record for the prior visit on [redacted]2023 described under Finding 3 above concluded when the RN documented "Patient dismissed" at 0354. 4.e. During interview with DO K on 02/05/2024 at 1600 they provided the following information about their encounter/interaction with Patient 21 during the early morning on [redacted]2023: * DO K stated that they conducted a physical exam of Patient 21 while the patient was on the gurney. The patient refused care and "called us all names ... said we were holding [them] against [their] will." The EMS providers and CRN all said the patient was at "baseline." EMS took the patient to a bench outside. * The DO stated that later the patient was brought back inside the hospital and taken to Triage Room 3. While there the DO stated the patient spit on the DO. The DO stated they offered the patient a sandwich and to spend the night, however the patient wanted to go to OHSU, so they let the patient go.	A2406		

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A2406	Continued From page 59 * The DO stated they considered the events that occurred outside as shown in the video-recording to be a continuation of the previous visit (described under Finding 3 above). * They stated the "total time" spent with Patient 21 was "45 minutes" in the ED and outside the hospital. ********** 5.a. The central log for Patient 21d reflected that they presented to the ED on [redacted] 2024 at 2219 with a "Chief Complaint" of "Weakness." The "ED Disposition" on the log was "Lwbs After Triage" on [redacted] 2024 at 2300. 5.b. The findings that follow for this encounter reflected inconsistencies between the EHR documentation, video recordings, SO reports, and interviews, and reflected that the hospital did not fulfill its EMTALA obligation for Patient 21d. For example: * A MSE that included an evaluation of the behavioral/psychiatric symptoms and distress the patient exhibited that brought them to the ED was not conducted. * There was no documentation by the MD who saw the patient. * SO reports reflect they were called to the room for a "pre code gray." * It was unclear how it was determined that this patient who exhibited behavioral/psychiatric symptoms had the capacity to participate in the AMA informed consent process that was documented in the EHR. * Although a "Vulnerable Patient Discharge (VPD) Safety Review" was initiated in accordance with the IJ Removal Plan, is was unclear why the VPD Competent RN had not gathered the IDT for review of Patient 21d's encounter to ensure they	A2406		

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A2406	Continued From page 60 received an MSE that included a behavioral health assessment. The patient was houseless, demonstrated behavioral/psychiatric symptoms, and had mobility and self-care impairments. 5.c. The medical record for Patient 21d's [redacted]2024 ED encounter was reviewed and included the following information: * An AMR ambulance report reflected that on [redacted]/2024 at 2159 EMS was dispatched for a "Code one for back pain ... [Patient] was in a wheelchair at the bus stop, [they] asked a bystander to call 911 for [them]." EMS arrived at the scene and found patient sitting in wheelchair "alert and breathing normally ... screaming out over and over, [they were] able to stand and sit on the gurney ... only would allow for a blood pressure and pulse oximetry ... would not take [their] jacket off for the blood pressure ... blood pressure was elevated ... was transported to the hospital of [their] choice for further evaluation ... would not allow for EMS to do a physical assessment." EMS arrived at PMH, 2 miles from the scene, at 2217. * The ED Care Timeline reflected the following chronology of events on [redacted]2024 for this encounter: - 2219 "Patient arrived in ED ... Arrival Complaint [ambulance] ... ED Information Exchange Resulted Abnormal Result ..." were recorded. - 2220 RN recorded "Means of arrival ... [ambulance]" - 2220 RN recorded "To room ED04." - 2223 RN recorded "Triage Start ... Arrived From ... (bus stop/homeless)" - 2224 RN recorded "Chief Complaints Updated Weakness (Generalized pain)" and "Pt BIBA code q with complaints of generalized weakness and	A2406		

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A2406	Continued From page 61 generalized pain. Pt reports 'someone broke all my bones'. Pt was seen at OHSU today with the same complaint ... Homeless ... pt ambulatory with little assistance to stretcher but would not ambulate to bed upon arrival." - 2228 RN wrote "Pt has adamentaly declined any vitals. Pt demanding a cigarette and coffee. Pt will not allow this RN to remove jacket for examination or to obtain vitals." - 2233 RN wrote "Charge RN at bedside to encourage patient to receive medical evaluation. Pt continues to decline medical evaluation. Pt demanding to leave. Security at bedside. Nursing supervisor at doorway." - 2235 RN wrote "Charge RN at bedside to explain AMA paperwork. Pt again offered medical evaluation by RN and provider. Pt continues to decline and requests to leave. Pt signed AMA form. MD aware." - 2238 RN wrote "Security at bedside to assist patient to bus stop per patient request. MD at bedside. Patient refused shoes offered to [them]. Pt ambulates with steady gait and walker assistance out of room. Pt talking in complete sentences. No acute distress." - 2300 RN wrote "Patient discharged ... ED Disposition set to LWBS after Triage." * The Medical record included the identical "Other Orders ... EDIE ED INFORMATION EXCHANGE ... (Abnormal)" result and recommendations found under Finding 3 above. - Please make an attempt to complete an up to date mental health assessment." * Medical record documentation also reflected: - A form titled "Leaving Facility without a Medical Screening Exam/LWBS" had been completed by an RN, reflected the "Reason for refusal of	A2406		

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A2406	Continued From page 62 treatment" was "'I don't want to [expletive] be here.'" It was signed and dated by the RN as [redacted]2024 at 2235, and was signed by the patient. - "Clinical Notes ... No documentation. Labs ... No documentation. Imaging ... No documentation. Procedures ... No documentation." - "Patient Education ... No documentation. Patient Instructions ... No documentation. After Visit Summary ... No documentation." 5.d. Patient 21d's [redacted]/2024 encounter was captured on hospital video recordings (without audio capability) from multiple interior and exterior camera views that showed the following: * 2217 EMS entered hospital through ambulance entry with the patient gurney, patient was seated and slumped/leaned to the right. * 2218 EMS moved gurney into ED Room 4 directly across from the nurses station. * 2220 MD H approached Room 4 and stood outside the doorway for 12 seconds, looked inside for two seconds, did not enter room, and walked away. * Between 2220 and 2232 and all the while the patient was in Room 4 multiple staff entered and exited the room repeatedly while other multiple staff lingered outside of the room, standing or milling near the room doorway, including one or two at a time of who sat on a gurney outside of the room. * 2232 MD H approached Room 4, stood outside the doorway and looked in for seven seconds, did not enter the room, and walked away. * 2233 CRN entered room with a piece of paper in hand. MD H approached and looked towards the room for two seconds. CRN exited room 30 seconds later with piece of paper in hand.	A2406		

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A2406	Continued From page 63 * 2235 MD H entered Room 4. * 2236 MD H exited the room after ~ one minute and two seconds. MD stood at or near the doorway for ~ 30 seconds, then walked away from the room down a hallway. * 2238 Pt ambulated out of room with a walker, wore pink socks and no shoes. A SO and an EDT who pushed an empty Stryker transport chair followed behind patient. At the ambulance entry door the SO took the walker from the patient who sat on the transport chair. * 2240 Pt exited building in transport chair pushed by a SO. * 2241 SO pushed patient in transport chair downhill towards street where bus stop located. 5.e. Review of a "Vulnerable Patient Discharge (VPD) Safety Review" form signed by the VPD Competent RN on [redacted]2024 at 2250, after the patient had left the hospital, reflected that the VPD RN "agrees that the discharge plan is safe and appropriate" and that the IDT had not been gathered to review the encounter further. The section of the form for the IDT review was blank. 5.f. A "Security Services Incident Report" regarding Patient 21d reflected an occurrence on [redacted]2024 at 2333 [sic]. The SO wrote that "I was called to a pre code gray in room # 4 for an uncooperative patient . As soon as I arrived, I noticed the patient was a frequent visitor to the hospital, [Patient 21] ... known to have aggressive behavior towards staff. As I entered the room, I could hear [the patient] yelling and cursing at staff saying [they] didn't want to be here. [Names of three RNs, HS, and CRN], were all standing outside the room. [CRN] and [HS] entered the room to talk to [the patient]. [Patient 21] was stating that [they] did not want to be seen at the	A2406		

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A2406	Continued From page 64 hospital and was asking to leave. [CRN] and [HS] both asked [the patient] multiple times if [they were] sure [they] didn't want to receive care from the hospital, which [patient] then replied multiple times that [they] didn't want to receive care. [MD H] also attempted to talk to [the patient], but [the patient] just said [they] wanted to not receive care. [CRN] then had [patient] sign some paperwork refusing care, which [patient] Signed. Then [Names of two RNs] attempted to provide shoes from our supply closet to [the patient], but [patient] refused them. I asked [the patient] how [they were] going to get home and [they] said [they were] homeless but wanted to take to [sic] bus, so I provided [them] a bus pass. [The patient] was having a hard time walking but refused to have me push [them] to the bus stop in a wheelchair. [Patient] attempted to use a walker that the hospital was providing [them] to use so [they] could make it to the bus stop but decided [they] would like to have me help [them] to the bus stop in a wheelchair. As I was escorting [the patient] to the bus stop in the wheelchair, was met by [other SO]. I brought [patient] to the bus stop on SE 32nd Ave. Once I helped [patient] to the bench at the bus stop, [other SO] and I begin to make our way back to the hospital, we noticed a bus pull up to the stop and as [patient] was attempting to board the bus the driver shut the door and drove away leaving [Patient 21] at the bus stop. After returning the wheelchair to the hospital [other SO] decided to head back to the bus stop to make sure the bus driver doesn't drive off without [the patient] again. I stayed up at the hospital. Nothing further to report." The report was electronically signed on [redacted]2024 at 1050. 5.g. A "Security Services Incident Report" by the other SO reflected the occurrence on [redacted]2024	A2406		

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A2406	Continued From page 65 at 2333 [sic]. The SO wrote that "Earlier in the shift, [another SO] escorted a discharged [Patient 21] to the bus stop. I assisted, and saw the bus pull up and leave without [the patient]. While on a patrol of the parking lots a few minutes later, I heard yelling coming from the bus stop located in front of the Providence Healing Place. As I approached, I saw [Patient 21] sitting on the ground in the bus shelter. I asked [the patient] if [they] needed medical attention and [they] said, 'No, need a cigarette'. I asked [the patient] if they needed assistance getting up from the ground, and [they] said, 'Yes. [Patient 21] asked if I could stay with [them] until the bus arrived and I agreed. I stayed with [the patient] until the bus arrived, and assisted [them] in getting to the door. The driver became irate with me for assisting [the patient] and I explained that the previous bus left without [the patient] and that I was assisting just [the patient]. The bus then pulled away and I cleared the call." The report was electronically signed on [redacted]2024 at 1548. 5.h. During interview with MD H on 02/06/2024 at ~ 1830 they provided the following information about their encounter/interaction with Patient 21 on [redacted]/2024: * They worked the 1700 to 0100 shift that began on [redacted]2024. * The patient arrived by EMS and there was difficulty getting them settled as the patient began to express they wanted to leave and staff had difficulty getting vital signs. * They looked at the patient's chart and saw that the patient had been to three other hospitals recently. * They walked into the room but didn't think they could force the patient to have an MSE. They stated they didn't know what the "boundaries	A2406		

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A2406	Continued From page 66 were" that would require them to "force a patient against their will" who didn't want to stay or "who was combative or resistive." The MD stated they were "not sure what to do." They "didn't know where the line was where I could do something." * The patient stated they only wanted cigarettes and had no other complaints, and MD H "didn't see this as an opportunity to do an MSE." * They didn't recall what the EMS report was. * They didn't make any notes, and didn't have "viable contact" with the patient. The MD stated they could hear what the patient was saying, they observed the patient briefly at the bedside, and they may have seen the patient "brushing away a nurse's hand." * They "didn't get into an interview with [the patient]." * In regards to whether MD H documented their contact and observations, they stated that "In retrospect and light of subsequent events and visits it would have been the more correct thing to do," to write a note. * MD H stated this was a "difficult dilemma." * Patient 21 was brought back to the hospital again at the end of the MD's shift and they "found out [the patient] was sick." ********** 6.a. A "NewsBank" media article regarding Patient 21 dated [redacted]2024 was titled "TriMet driver said [they] felt 'forced' to pick up ..." The article reported that the incident occurred on [redacted]2024 at ~ 2325. It stated that "A TriMet bus driver reported that a [person] who soiled [their] clothes and wore no shoes was put on [the] bus by a security guard from Providence Milwaukie Hospital after another bus may have declined to take [them]. The driver radioed in that [they] felt [they] didn't have a choice in taking the [person]	A2406		

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A2406	Continued From page 67 and that the guard had 'forced' the [person] onto the bus, according to Tri Met dispatch audio. A TriMet dispatcher ended up calling 911 for a medical response to help the [person] the evening of [redacted] ... The TriMet bus encounter occurred round [2325] ... The [person], who was not identified, had gotten on and off the bus at least twice, demanded to be dropped off in the opposite direction of the northbound bus route and ended up on the ground outside the bus, requesting a medical response, according to Tri Met radio dispatch recordings ... The following account is based on Tri Met dispatch recordings: After the [person] first boarded the northbound Tri Met bus 75 outside Providence Milwaukie Hospital, the driver soon put the ramp down to help [the person] get off but [the person] fell to the ground. Once [the driver] helped [the person] up, [the person] got back on the bus, demanding to go the opposite direction. [The driver] told [the person the bus] couldn't go the opposite way and called dispatch to ask for guidance from a supervisor. The driver deployed the ramp again on the bus and the [person] got off. 'This [person] is sitting on the ground right now,' the driver told the supervisor by radio. The driver was instructed that a supervisor would respond and a co-worker was calling 911 to do a welfare check. 'Yeah, [the person] wants medical,' the driver radioed to dispatch, 'but I just picked [them] up from the hospital and went maybe four blocks.' The driver waited, and the [person] crawled back onto the bus. The dispatcher told the driver to reassure [the person] that an ambulance was on its way. 'Now [the person's] saying I hurt [their] hand. I don't like being in this position at all,' the driver told dispatch. 'I felt like [the person] was forced on me and thought it was going to be like this either here or at Pier Park,' the driver added,	A2406		

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A2406	Continued From page 68 referring to the final destination of [their] bus route. 'My hands are shaking just having to deal with this,' the driver said. TriMet's involvement ended at [2343] ..." "Pier Park" the final destination the driver referred to was ~ 15 to 18 miles from PMH. 6.b. Review of PMH internal investigation documentation related to Patient 21's encounters included the following document titled "Transcription of five TriMet audio files." The transcription consisted of conversations between a TriMet bus driver and TriMet dispatch. The driver's statements about their experience with Patient 21 included: "Driver: The [PMH] security guard put this [person] on my bus ... [This person] used the bathroom on [themselves]. Now [they] said [they] wanted to get off the bus, [they] got off then I helped [them] get back on the bus. [They] said [they want] to go to Milwaukie, but I'm not going to Milwaukie, so I don't know what to do ... [The person] says [they want] to go two blocks and then go off, but in the other direction ... I'm at a bus stop now ... Now [they want] the ramp down but the last time [they] put the ramp down I put the ramp down [they] got off and fell on the ground and I helped [them] up. [They] got back on the bus. What should I do? If [the person] goes down and falls, then what? ... I just deploy [sic] them ramp and [they are] getting off now ... This [person] is sitting on the ground right now. I mean [they've] used the bathroom on [themselves] ... I'll ask [them] if [they want] medical ... [The person] wants medical, but I just picked [them] up from the hospital and I went maybe four blocks ... I can't leave because now [they're] crawling back on the ramp ... [They're] asking me to help [them] up but the last time I helped [them] now [they're] saying I hurt [their]	A2406		

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A2406	Continued From page 69 hands ... I don't like being in this position at all ... Well now [they've] crawled back on the bus ... There's two Milwaukie police cars right here, now, talking to [the person]. One of [the officers] knows [the person's] name ... my hands are shaking from having to deal with this." ********** 7.a. The central log for Patient 21e reflected that they presented to the ED on [redacted] 2024 at 0010 with a "Chief Complaint" of "Pain." The "ED Disposition" on the log was "Discharge" on [redacted] 2024 at 0654. 7.b. The findings that follow for this encounter reflected discrepancies and contradictions within the EHR, inconsistencies between the EHR documentation and video recordings and interviews, and reflected that the hospital did not fulfill its EMTALA obligation for Patient 21e. For example: * A MSE that included an evaluation of the behavioral/psychiatric symptoms and distress the patient exhibited that brought them to the ED was not conducted. * Although the physician documented in the medical record and stated during interview that an IV antibiotic was given to the patient, the physician ordered IV antibiotic treatment had not been administered. * It was unclear how it was determined that this patient had the capacity to participate in review of discharge instructions, had the ability to make a follow-up appointment with a PCP or to get an antibiotic prescription filled after discharge, or was capable of understanding the risks of refusal of treatment. * Although a "Vulnerable Patient Discharge (VPD) Safety Review" was initiated in accordance with	A2406		

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A2406	Continued From page 70 the IJ Removal Plan, it was unclear why the VPD Competent RN had not gathered the IDT for review of Patient 21e's encounter to ensure they received an MSE that included a behavioral health assessment. The patient had not received ordered IV antibiotic treatment, full vital signs had not been reassessed for more than four hours, they were houseless, demonstrated behavioral/psychiatric symptoms, and had mobility, continence, and self-care impairments. 7.c. The medical record for Patient 21e's [redacted]/2024 ED encounter was reviewed and included the following information: * An AMR ambulance report reflected that on [redacted]2024 at 2349 EMS "Arrived on scene to a bus stop. [Patient 21e] was found sitting upright on the sidewalk. Pt was complain [sic] of pain and would not elaborate further. Pt stated [they] wanted to see a doctor. Pt was assisted to the gurney and loaded into the ambulance. Vitals were taken ... Pt was verbally abusive and ... [loudly] ... 'don't touch me' which made assessment difficult. Pt had urinated [themselves]. Pt stated the pain was everywhere. Pt refused to answer any other questions. Pt transported code 1. Primary impression: Behavioral/Psychiatric - unspecified ... Primary symptom: Pain extremity." EMS arrived at PMH, .5 miles from the scene, on [redacted]2024 at 0007. * The ED Care Timeline reflected the following chronology of events on [redacted]2024 for this encounter: - 0010 "Patient arrived in ED" - 0011 "Arrival Complaint [EMS]" - 0012 MD J recorded "Provider Contact Initiated" - 0013 "ED Information Exchange Resulted Abnormal Result ..." was recorded.	A2406		

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A2406	Continued From page 71 - 0024 RN recorded "Chief Complaints Updated Pain (Pt reports pain everywhere)" - 0025 RN recorded "Vital Signs ... Temp: 38.2 °C (100.8 °F) ! Pulse: 144 Resp: 22 BP 161/105 ! SpO2: 93 % Temp Source: Oral ... Pain Rating (0-10): Rest: 10 ..." - 0026 RN recorded "Pt BIBA for c/o pain. Pt unable to tell writer exactly where the pain is. Pt is Loud, Hostile and vulgar in triage. Security present." - 0030 RN recorded "Cognitive/Neuro/Behavioral WDL: WDL ... Morse Fall Risk Level: High" - Beginning at 0034 MD orders included labwork, a CXR, an ECG, IV fluids, a dose of IV ketorolac (Toradol) and those were resulted and implemented. - 0039 RN recorded "To room ED14" - 0044 RN recorded "BP: 183/105 ! " - 0201 RN recorded "Pulse: 127 ...BP: 154/92 ! ... SpO2: 95 %" - 0246 RN recorded "Temp: 37.7 °C (99.9 °F)" - There are no entries after 0246 until 0440. - From 0440 until 0532 all entries are related to labwork completion or results. - 0532 MD J recorded "Orders Placed Medications - cefTRIAXone (ROCEPHIN) IVPB 2 g" - 0533 MD J recorded "ED Disposition set to Discharge" - 0534 MD J wrote "Discharge Orders Placed Medications - cephalexin (KEFLEX) 500 mg capsule" - 0538 EDT recorded "Pulse: 104" - 0626 RN wrote "Additional Note: pt demanding to leave at this time, requesting iv removed and new socks. pt able to verbalize that [they are] discharged and has a plan to catch bus with one of [their] bus tickets in [their] pocket. pt is ambulatory with assistance, but wheeled down to	A2406		

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A2406	Continued From page 72 bus stop due to pt c/o pain with long distance walking, pt refused shoes." - 0630 RN recorded "AVS Printed" - 0642 RN recorded "From ED14 to room OTF" - 0647 RN recorded "Medication Not Given cefTRIAXone (ROCEPHIN) IVPB 2 g - Dose: 2 g ; Rate: 100 mUhr ; Route: Intravenous ; Reason: Patient/family refused ; Scheduled Time: 0535" - 0651 RN recorded "Peripheral IV Line ... Removal Date/Time: [redacted]24 0651" and "Care Handoff Report Given to: Other (Comment) (pt catching bus per [their] request) ... Mobility at Departure: Wheelchair Departure Mode: By self (wheeled out by security down to bus stop)" - 0652 RN wrote: "Did patient/guardian/caregiver verbalize understanding of discharge plan and confirm ability to care for patient/self at current level of need? yes. Who was provided with discharge information? Patient. Medications discussed and patient/caregiver verbalized understanding? Yes. Patient advised to avoid alcohol consumption and operation of heavy machinery or motor vehicles for 24 hours? N/A. Is patient able to safely return to prior living environment, based on patient's mobility and ability to perform AOL's? If patient is returning to a care facility, did you confirm that the facility can provide the appropriate level of care? yes. Patient discharged safely to Other pt homeless, wants to catch bus to [their] next destination. Transportation mode: bus with bus ticket. Was this transportation mode determined to be the safest way to transport patient? yes. This patient's vitals documentation is up to date and the provider was notified if any outside the normal range prior to patient discharge. yes.	A2406		

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A2406	Continued From page 73 Patient condition at time of D/C, to address the presenting complaint: Pt given rx upon dc, appears at baseline, speaking in full sentences, leaving coffee and snacks. Verbalized understanding of dc instructions, rx, and follow up plan." - 0654 RN wrote "Patient discharged." * The Medical record included the identical "Other Orders ... EDIE ED INFORMATION EXCHANGE ... (Abnormal)" result and recommendations described under Finding 3 above. * On [redacted]2024 at 0357 MD J electronically signed the final version of their "ED Provider Note" that included the following information: - "[Patient 21] with a history of bipolar, coronary artery disease, chronic pain, COPD, fibromyalgia, gastric bezoar, urinary retention, alcohol abuse, heroin abuse, subdural hematoma, hypertension, bowel syndrome [sic], ischemic cardiomyopathy, opioid dependence, diazepam dependence, heart failure, being dependence, homelessness, failure to thrive, and hysterectomy who seen [sic] numerous times at numerous different facilities in the last several days with numerous and vague complaints and presents today with a vague complaint of 'pain all over.' The patient's physical exam was remarkable for a temperature 38.2, pulse of 144, generally disheveled appearance, flight of idea, tangential thoughts, ambulating speech ... urine was remarkable for 4+ bacteria, 5's and white blood cells by peripheral, 1+ leukocyte esterase, and positive nitrates ... chest x-ray revealed no evidence of an acute process ... labs (CBC, CMP, troponin, BNP, lactic, alcohol) were remarkable for a BNP of 855, potassium 3, and white blood cell count of 12.1 ... urine remarkable for amphetamines and THC ... I	A2406		

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A2406	Continued From page 74 felt that the patient's clinical picture was most consistent with pyelonephritis and methamphetamine abuse." - "Medical Decision Making Problems Addressed: Homelessness: chronic and illness or injury. Methamphetamine abuse (HCC): chronic illness or injury. Pyelonephritis: acute illness or injury that poses a threat to life or bodily functions ... Risk - Prescription drug management. Decision regarding hospitalization. Diagnosis or treatment significantly limited by social determinants of health. Risk Summary: High." - "ED Course Summary and Disposition - [Patient] was initially given IV fluids, [ceftriaxone (Rocephin)], and Toradol. On reevaluation [they] had improved. After considering the risks and benefits of inpatient versus outpatient treatment, I felt that stable and appropriate for outpatient management. [Patient 21] agreed to follow-up with a primary care provider for reevaluation in the next 2 to 3 days. I discussed any results, examination findings, disposition, treatment plan, potential medication side effects, appropriate follow-up, and criteria for returning to the Emergency Department with the patient prior to disposition. [Patient 21] understood and agreed to the plan." - "ED Medication Administration from [redacted] 2024 0010 to [redacted] 2024 0357 ... cefTRIAXone (ROCEPHIN) IVPD 2g ... Not Given ..." - "Impression 1. Pyelonephritis 2. Methamphetamine abuse (HCC) 3. Homelessness." - "ED Prescriptions cephalexin (KEFLEX) 500 mg capsule Take 1 capsule by mouth 4 times daily for 40 doses." - "Follow up [Providence Medical Group] or ED Follow Up Portland Oregon [phone number] In 3 days."	A2406		

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A2406	Continued From page 75 - "History of Present Illness ... [Patient] is a very challenging historian who struggles to tell [their] own history of present illness, however as best I can tell [their] complaint of pain refers to [their] chronic pain, and not acute pain or focal pain. [Patient] request both trazodone for sleep as well as coffee. [Patient] vaguely endorses a cough, but denies other chest/respiratory complaints. [Patient] denies GI/abdominal complaints ... denies new neck/back complaints, genitourinary complaint, ENT complaints, skin changes, extremity complaints, trauma, or other specific or general complaints. [Patient] describes [themself] as otherwise feeling well." - "Physical Exam Vital Signs: (Reviewed) Temp: (!) 38.2 (100.8 °F) Pulse: 144 Resp: 22 BP: (!) 161/105 Sp02: 93 % Constitutional: ... No acute distress. Non-toxic appearance. Rambling speech. Flight of idea. Somewhat disorganized thoughts ... Neurologic: Alert. No motor deficits. No sensory deficits. Normal coordination. Psychologic: Normal behavior. Normal affect. Oriented." - "Procedures None." * Medical record documentation also included: - Medication administration records that reflected "cefTRIAXone (ROCEPHIN) IVPB 2 g ... [redacted]/24 0647 Not Given Patient/family refused ... [RN Name]." However, there was no documentation to reflect the circumstances around the refusal and no documentation to reflect the physician had been notified of the refusal. - A 10-page "After Visit Summary" that reflected it was "Printed by [ID number] at [redacted]024 6:30 AM" included the following information: "... START taking: cephalexin (KEFLEX) ... Pick up these medications from any pharmacy with your printed prescription - cephalexin. Follow up with PMG or	A2406		

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A2406	Continued From page 76 ED FOLLOW UP in 3 days (around [redacted]2024) Contact: Portland Oregon [phone number]." 7.d. Patient 21e's [redacted]2024 encounter at discharge was captured on hospital video recordings (without audio capability) from multiple interior and exterior camera views that showed the following: * 0632 Patient ambulated from ED treatment room into corridor with hands-on assist by two RNs, when they approached the nurse's station the patient used the length of the counter to support their steps, patient was assisted to Stryker transport chair and pushed into ED WR/lobby by two RNs. * 0635 SO pushed patient in transport chair from ED WR/lobby to outside of ED, following by four other SOs. * 0636 SO pushed patient in transport chair downhill towards street where bus stop located, followed by two other SOs. 7.e. Review of a "Vulnerable Patient Discharge (VPD) Safety Review" form signed by a VPD Competent RN, dated on [redacted]2024 and untimed, reflected that the VPD RN "agrees that the discharge plan is safe and appropriate" and that the IDT had not been gathered to review the encounter further. The section of the form for the IDT review was blank. During interview with the EDM on 01/31/2024 at ~ 1130 they confirmed that Patient 21e's encounter associated with this untimed VPD review form began on [redacted]2024 at 0010. 7.f. An undated PMH internal investigation document titled "Interview with [MD J]" included the following information provided by MD J about their encounter/interaction with Patient 21 on	A2406		

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A2406	Continued From page 77 2024. * MD J stated "I know [Patient 21] from multiple visits. I hope you can get a flavor from [their] chart of how [the patient] interacts with resources in our community. They walked into our waiting room from [their] own accord. Rambling hard to narrow down [their] chief complaint. It seemed to be pain but [they] couldn't localize it. [There were] asking for coffee and trazadadone [sic]. They had a fever and [the patient] was sick in some way, [their] pulse was elevated. I couldn't tell whether that was pain or meth. So I went looking for infection. I did a bunch of different tests [their] white count was 12 it wasn't terrible ... urine came back with +bacteria in [their] urine so sounded like pretty solid source for [their] fever. I gave [the patient] fluids and IV Rocephin ... I went back to check on [the patient] and [their] vitals had gotten better. And [they] wanted to be discharged. I was aware that we are under the microscope and that this patient is in that vulnerable population. Having assessed [the patient] and bookending [them] with [their] assessment and final assessment, vitals had improved source of fever treated. I was surprised that [the patient] came back and what happened next." * In regards to discharging Patient 21 for "following up on [their] UTI and antibiotics on [their] own self care" MD J stated "I only have 2 directions admit them or let them go. It is a hard decision ... It is important to know if the person can take the next steps on their own. You don't quite know if someone can pull it off. But I thought [the patient] could pull it off if [they] wanted to. [The patient] was saying that [they] wanted to go and that [they] knew next steps. There is a certain amount of accountability that people need to bring to the situation to take their own self-care, they have to also participate. [Patient 21] told me that	A2406		

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A2406	Continued From page 78 [they] understood and that [they] would follow up within the next 2-3 days. [They] didn't deviate from a baseline and become agitated. [They were] at [their] baseline. What in another person might make me react in a personal way, [Patient 21] is just kind of a yelling rambling person. I didn't think [they were]different from their baseline. [They] didn't seem acutely on meth. [Their] ideas and emotions are tangential." 7.g. In an email from MD J to hospital staff dated and timed as received on 02/02/2024 at 1447 MD J confirmed the internal interview information described in this finding, and wrote that "I think that's a pretty solid summary ... hits the key points ... there's nothing inaccurate ... [MD J]" 7.h. An undated PMH internal investigation document titled only "[Patient 21's name and MRN #] included the following: "During [2024] visit at 0012 diagnosed with Pyelonephritis by [MD J], our concern is that [Patient 21] was found to be stable and given an outpatient rx and taken to the bus by security Provider felt [the patient's] condition had improved after hydration, not sure what made [the MD] feel [the patient] had improved." 7.i. During interview with staff on 01/31/2024 at ~ 1130 the EDM agreed that it was "not likely" that Patient 21 would go to a PCP or get a prescription filled. Staff present also stated there was no behavioral health assessment because there was no social work availability at the time of the encounter. ********** 8.a. A "Security Services Incident Report" regarding Patient 21f reflected that on 2024	A2406		

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A2406	Continued From page 79 at 1322 "I was doing a routine patrol of the parking lots. When I arrived to the Dwyer street side of lot F I was flagged down by bystanders and employees regarding a [person] laying in the grass screaming for help. Upon investigating I recognized the person as a former [Patient 21]. I asked [Patient 21] if [they] needed medical attention and [they] replied yes. As [they were] outside of the [Rapid Response Team] response area I called 911 and requested an ambulance. I offered to help [Patient 21] sit up but [they] demanded that I not touch [them] and then accused me of Sexually assaulting [them]. At this point I took several steps back and waited for the ambulance to arrive. A short time later [Patient 21] sat up and then began to scoot across the grass and out into the roadway. I then reengaged [the patient] to prevent [them] from being hit by cars traveling on the road way. A short time after a Black vehicle arrived. The driver was ... the Behavioral Health Specialist with the [MPD]. With [them] was ... the Houseless Liaison for the City of Milwaukie Loveone Outreach program. They stated that they were sent by Milwaukie dispatch and asked for a brief summary of the situation. After giving them my summary they engaged with [Patient 21] and helped [them] off the ground and over to their vehicle. [The Behavioral Health Specialist] used [their] city issued radio to speed up an ambulance to our location. I stepped back to not cause any more tension with [the patient] and waited for the Ambulance to arrive. Clackamas fire and rescue arrived at 14:20 and assisted [the patient] into the Ambulance. They then transported [Patient 21] to [PMH]. I cleared the call at this time." The report was electronically signed on [redacted]/2024 at 0855. 8.b. A Clackamas County Fire District ambulance	A2406		

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A2406	Continued From page 80 report regarding Patient 21f reflected that on [redacted]/2024 at 1337 they were "dispatched per request by [PMH] Security and [MPD] for a send 1 ambulance transport." The report reflected that upon arrival at 1354 MPD "reports that they called for a subject who voluntarily wants to be taken to the ER. Pt advised that since we are in the parking lot we would take pt to the ER at the hospital [they are] at. Pt agreed. Pt refused VS or any in depth assessment. Pt reports that [they have] pain all over and that's whey [they need] the ER. Pt is able to stand and transfer onto gurney. Pt appears to be having a mental health issue as [patient] yells and screams at [EMS personnel] for asking questions. Pt appears to be very agitated. Upon arrival at er [sic], Pt is taken out to triage. Pt report given to Triage RN." 8.c. The central log for Patient 21f reflected that they presented to the ED a second time on [redacted]2024 at 1404 with a "Chief Complaint" of "Followup Medical Problem." The "ED Disposition" on the log was "Discharge" on [redacted]2024 at 1644. 8.d. The findings that follow for this encounter reflected discrepancies and contradictions in the EHR, inconsistencies between the EHR documentation and video recordings and SO reports and interviews, and reflected that the hospital did not fulfill its EMTALA obligation for Patient 21f. For example: * The patient was moved from the ED WR/lobby to the exterior ambulance entry where the physician eventually interacted with them in the driveway. * Description of the patient's behaviors reported by the physician about "violent" behaviors, and about behaviors that scared other patients as	A2406		

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A2406	Continued From page 81 being the reason the patient was moved to the exterior of the hospital, was not consistent with documentation in the medical record or video recording. * It was unclear the extent of MSE that was conducted, and it did not include an evaluation of the behavioral/psychiatric symptoms the patient was brought to the ED, and which staff asserted the patient exhibited during the encounter, such as "violent ... verbally abusive ... super agitated ... very scary." * The RN declined the patient's pleading to go back inside the hospital and proceeded to administer medication to them where they sat in the exterior ambulance entry. * It was unclear how it was determined that this patient who exhibited behavioral/psychiatric symptoms had the capacity to participate in a review of discharge instructions. * Although interviews from two sources indicated the CRN stated they completed a "Vulnerable Patient Discharge (VPD) Safety Review" for this encounter, there was no evidence that reflected one had been initiated in accordance with the IJ Removal Plan for this patient who was houseless and who exhibited behavioral/psychiatric symptoms. During interview with the EDM on 01/31/2024 at ~ 1130 they confirmed that a VPD review form had not been completed for this encounter. 8.e. The medical record for Patient 21f's second [redacted] 2024 ED encounter was reviewed and included the following information: * The ED Care Timeline reflected the following chronology of events on this second [redacted] 2024 encounter: - 1404 "Patient arrived in ED" and "Arrival Complaint [patient's first name]" were recorded.	A2406		

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A2406	Continued From page 82 - 1408 RN recorded "Is the chief complaint likely related to infection? Infection likely: No" and "Chief Complaints Updated Followup Medical Problems" - 1409 RN wrote "Pt BIBA after being seen 'rolling around' in the yard of the hospital. Pt only compliant is 'My body hurts'. Pt tangential in triage ... Residence: Private." - 1410 RN recorded "Cognitive/Neuro/Behavioral WDL: all, Level Of Consciousness: other (see comments) (Pt unable to remain focused to speak with RN)." - 1410 "ED Information Exchange Resulted Abnormal Result ..." was recorded. - 1411 RN recorded "Vitals - Temp: 36.6 °C (97.9 °F) Pulse: 99 Resp: 16 BP: 128/79 Sp02: 96 %" - (Video-recording at 1449 described below in these findings showed the patient was pushed in a wheelchair to outside the building at the the ambulance entry and parked there at that time. This was not reflected in the medical record.) - 1505 MD A recorded "Provider Contact Initiated" - 1506 MD A ordered "Medications - acetaminophen (TYLENOL) tablet 1,000 mg; QUEtiapine (SEROquel) tablet 50 mg" - 1511 MD A recorded "ED Disposition set to Discharge" - 1516 RN recorded "Medication Given" for the ordered Tylenol and Seroquel. (Video-recording at 1519 described below in these findings showed the patient was pushed in the wheelchair from the parking lot towards the street and bus stop at that time. This was not reflected in the medical record.) - 1534 RN recorded "Patient room in ED To room HALL 10." - 1547 LCSW wrote "SW received referral from Charge RN, POST-patient's discharge, re: request for care conference. [Patient 21] with	A2406		

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A2406	Continued From page 83 prior medical history of Bipolar I Disorder, Anxiety, Depression and Polysubstance Use who presented to the ED today with a complaint of pain/body aches. Per report from Charge RN patient was medically screened and discharged, with patient requesting to leave. SW reviewed EMR, patient is a frequent visitor various Portland Tri County emergency departments. SW checked most recent EDIE report which was updated earlier today, with care recommendations to assess patient for [their] ability to care for [themselves]. It also indicates that patient has been banned from most of the shelters in the area due to behaviors and incontinence. SW notified Charge RN, however patient had already left the building and when Providence Milwaukie Hospital Security approached [patient, the patient] refused to return with them to the ED. Updated ED Care Plan added to the chart." - 1634 RN recorded "Patient transferred From room HALL 10 to room ED11." - 1642 RN wrote "Additional Note: Charge RN [Name] will addended [sic] this chart, Chart needed to be closed to readmitt [sic] the patient. [Flag symbol]." - 1644 RN recorded "Patient discharged." - 1644 MD A recorded "Charting Complete." * The Medical record included "Other Orders ... EDIE ED INFORMATION EXCHANGE ... (Abnormal)" result similar to information identified under Finding 3 above, that included updated "Care Recommendation." "ED Care Guidelines from Tri-County 911 Last Updated: 1/2/23 1:33 PM Care Recommendation: -Complete assessment to determine if [client] can be placed on a 14 day hold to assess current needs and appropriate level of care.? -[Client] has recently been found within the	A2406		

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A2406	Continued From page 84 community covered in feces and urine and it is believed that [they] cannot care for basic needs.? -[Client] recently observed laying on train tracks and continues to place self in situations where imminent and serious harm could take place. ? -[Client] often reports generalized pain but cannot identify what body location is affected, frequently struggles to provide an accurate medical history.? -[Client] utilizes services within Clackamas and Multnomah County and frequently requests taxi rides to shelters to access services. Due to the inability to care for basic needs, [client] is not able to access shelter based services and frequently is routed to the ED.?" * On [redacted] 2024 at 1614 MD A electronically signed an "ED Provider Note" that included the following information: " Medical Decision Making - The pt was triaged to Room [no room number recorded] and the nursing notes were reviewed. In summary, this is [Patient 21] with a history of bipolar disorder, coronary artery disease, chronic pain, COPD, fibromyalgia, gastric bezoar, urinary retention, alcohol abuse, heroin abuse, subdural hematoma, hypertension, bowel syndrome, ischemic cardiomyopathy, opioid dependence, diazepam dependence, methamphetamine abuse, heart failure, homelessness, failure to thrive, and hysterectomy, who presents for evaluation with agitated behavior. [Patient] is here requesting a dose of Tylenol, and Seroquel. The patient's physical exam was remarkable for stable vital signs, no fever. The patient was alert, and oriented, although [they] did have some evidence of thought disorder. [They] denied any suicidal or homicidal ideation, [they] had some mild psychomotor agitation. I reviewed the available chart records for a recent provider note,	A2406		

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A2406	Continued From page 85	A2406		

discharge summary, or significant imaging studies for additional understanding of the patient's clinical presentation. This patient presents for evaluation to the emergency department, without any specific complaint except for a request for a dose of [their] Tylenol and Seroquel. The patient reportedly in triage told the nurse that [their] whole body hurts, which is a common presenting complaint for this patient. Patient does have a history of chronic pain issues. When I interviewed the patient, [they] only requested Tylenol and Seroquel, which I provided for [them]. [Patient] did not have any further complaints, and wanted to leave, and refused to come into the emergency department for further evaluation, and refused any further medical workup at this time. The patient was discharged, [they were] instructed to return for any other concerns. Results, examination findings, disposition, treatment plan, potential medication side effects, and criteria for returning to the Emergency Department were discussed with the patient prior to discharge. They understood and agreed to the plan. Problems Addressed: Agitation: acute illness or injury. Bipolar affective disorder, remission status unspecified (HCC): acute illness or injury. Impression 1. Bipolar affective disorder, remission status unspecified (HCC) 2. Agitation. ED Prescriptions - None. Follow up - No follow-up provider specified. History of Present Illness ... history of bipolar ... who presents for evaluation with agitated behavior. The patient is an exceedingly poor historian, and has had multiple medical evaluations and workups in this emergency department and multiple local area emergency departments recently. Upon my interview of this patient, [they state] that [they] simply wanted a dose of Tylenol, and Seroquel. [They were] seen

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A2406	Continued From page 86 earlier today, and had a full medical workup at that time. History was obtained from the patient ... Ancillary Studies - All lab results, imaging studies, and other diagnostic tests available at the time of disposition were reviewed." * On [redacted]/2024 at 1900 an RN electronically signed an ED Note that reflected "Late entry: Pt initially refusing to be seen and requesting to leave. Pt then requested tylenol and Seroquel and would like to leave. [MD A] was notified and evaluated pt. Pt was given medication per request/order. Pt was taken to bus by security in wheelchair. Pt was provided a warm blanket prior to leaving. This RN discussed needing a care conference with [SW] due to pts [sic] condition, behavior and ED usage. SW was able to locate a note that stated pt be evaluated for competency and ability to care for self. Once this information was found this RN immediately called security to [sic] at 1524 to please bring pt back to ED Pt continued to refuse and was off property. Discussed need for calling police to bring pt back to ED on Hold for evaluation with [MD A] then ED manager. This RN was then notified by RN coming back on shift that pt was being transported via ambulance back to ED." * Medical record documentation also reflected: - "Labs ... No documentation. Imaging ... No documentation. Procedures ... No documentation." - "Patient Education ... No documentation. Patient Instructions ... No documentation. After Visit Summary ... No documentation." 8.f. Patient 21f's second [redacted]/2024 encounter was captured on hospital video recordings (without audio capability) from multiple interior	A2406		

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A2406	Continued From page 87 and exterior camera views that showed the following: * 1402 EMS transported patient, who sat upright on gurney, into ED WR/lobby and patient transferred self to couch. * 1404 EMS exited WR/lobby and ED staff person approached patient and applied wrist band. * 1405 Patient walked through WR/lobby to ED entrance and to outside of hospital. * 1406 Patient returned from outside to WR/lobby and walked to registration desk. * 1407 Patient walked back to couch. Mouth can be seen moving as if talking to self. Patient walked toward registration desk, then toward triage rooms. * 1411 CRN, EDT, and SO entered WR/lobby and interacted with patient * 1412 Staff returned into ED and patient remained in WR/lobby * 1416 Patient walked back outside * 1420 SO pushed patient who sat on a Stryker transport chair from outside and parked the chair in WR/lobby. * 1438 Patient transferred self from Stryker chair into a wheelchair that was parked inside the ED entrance door and wheeled self to outside of hospital. * 1440 Non-staff person pushed patient back into the WR/lobby. Patient wheeled self toward registration desk and triage rooms. * 1446 Patient and wheelchair move completely out of camera view towards the entryway into the ED near Triage Room 3. * 1447 Three SOs and CRN entered the WR/lobby through the registration desk door. CRN returned back behind the registration desk and the SO's moved in the direction that the patient had gone in toward Triage Room 3 and the ED entry.	A2406		

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A2406	Continued From page 88 * 1449 Three SOs pushed wheelchair with patient from inside the ED through the ambulance entry door to exterior of hospital. They parked the wheelchair near the ambulance entry door. All three SOs returned into the hospital through the ambulance entry after they swiped a badge to open the door. The patient was left outside of the hospital unattended and unsupervised. * 1451 Patient wheeled self nearer to ambulance entry door. * 1454 Three SOs exited ED through ambulance entry door and pushed patient's wheelchair back to the original parked position. * 1503 MD A exited ED through ambulance entry door and approached patient who had wheeled self into the driveway near an ambulance that had arrived with another patient. * 1504 CRN and two SOs exited ED and stood by patient and MD A * 1504 MD A and CRN returned into ED * 1505 SOs returned patient to the original parked position near the ambulance entry door. * 1507 SOs returned into ED and left patient outside of the hospital unattended and unsupervised. * 1510 Patient wheeled self away from entry toward the parking lot. * 1513 Two SOs exited the ED through the ambulance entry door, approached patient, and wheeled patient back toward the hospital after unlocking the wheelchair brakes. * 1515 CRN exited the ED through the ambulance entry door and was observed to carry objects of different sizes in both hands, one of which appeared to be a cup. CRN gave those items to the patient during a series of movements. * 1518 CRN returned to inside the ED. * 1518 SO placed blanket over patient's lap and	A2406		

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A2406	Continued From page 89 pushed the patient in the wheelchair away from the hospital toward the hospital driveway that led to the street. 8.g. A "Security Services Incident Report" regarding Patient 21f reflected that on [redacted]2024 "At approximately 15:13 Security was notified by ED [CRN] of a Person of Concern in the Ambulance Bay. I, [SO], and recruit [SO] responded and contacted [Patient 21] who was sitting in a wheelchair in the Ambulance parking area screaming. [They were] screaming that [they] wanted to 'go back inside the ED' so I began to push [patient] inside through the Ambulance Bay entrance. However, [CRN] exited and came outside stating that [they] had medications for the patient and that [patient] was being discharged and would need an escort to the Bus Stop. The patient received oral medication which [they] took without issue. I asked [CRN] if the patient had received [their] discharge paperwork, but the patient interrupted stating that [they] didn't need it. I asked CRN if [they] had completed the Vulnerable Patient Discharge (VPD) Safety Review, and [they] replied, 'Yes.' I wheeled the patient down the driveway and to the covered Bus Stop near the 201 Building on SE 32nd Ave and [they] got out of the chair and sat down on the bench. As I was about to return to the Hospital, I got a phone call on my personal cellphone from [CRN] asking me to bring the patient back up to the ED because 'Social Work would like to speak to [the patient].' I informed the patient of this and the patient stated that [they] did not want to go back up to the ED. I asked [patient] approximately 4 times if [they] would like to return to the hospital to talk to a Social Worker and see about resources, and [they] responded NO and shouted other	A2406		

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A2406	Continued From page 90 profanities at me. I called [CRN] back to tell [them] that the patient was refusing to return to the ED. [CRN] replied, "That's okay, let [patient] go, and if [patient] returns then we have a plan for [them]." The phone call ended, I offered the patient a friendly parting comment, returned to the Security Office, gathered all of the available information for this report, and cleared at approximately 15:35." The report was electronically signed on [redacted]2024 at 0859. 8.h. Two PMH internal investigation documents titled "Interview with [MD A]" and dated 01/08/2024, one timed as at 1025, reflected the following information provided by MD A about their encounter/interaction with Patient 21 on [redacted]2024: * "When I came in to work the charge RN asked me to evaluate this patient but [the patient] wouldn't come into the ED. The patient was yelling and screaming in the lobby. We moved [the patient] to the ambulance bay. [They] asked me for a dose of Tylenol and Seroquel. If you review [the patient's] chart [they go] to many EDs and is challenging. [They have] a hx of schizophrenia. I offered what I could. [They were] dressed enough I suppose. [They] looked agitated, but when it came down to [their] orientation questions [their] understanding of the situation the date time [they were] oriented x3. In the past when [the patient] is that oriented there has not been any attempts to force [them] for treatment. So we offered [them] food/drink and gave [them] the medication. [The patient] was assisted to the bus stop. Like [they] knew [they were] at PMH [they] wanted certain meds and that was it. [The patient] is difficult to get a history out of at best. I did my best to meet [their] needs. I offered for [them] to go into the ED for further	A2406		

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A2406	Continued From page 91 evaluation but [they] declined." * "... one of the reasons we had to move [the patient] away from the lobby was because [they were] scaring visitors." * "[Patient 21] knew that [they were] brought by EMS, [they] didn't have a good understanding why but knew [they] wanted meds. At best, [they are] very difficult in general. I did my best to meet [their] needs and what [they] came into ED for. Other than meds, [the patient] was very ademate [sic] that [they] did not want anything else. I offered [them] to come into ED and get further testing, but [they] said no. I didn't go into [the patient's] personal life ... I wasn't quite sure what direction; basically I was just there to help [the patient] in whatever way [they] requested me to do." * In regard to MD A's understanding of why the patient had been brought into the ED for the MD stated "[The patient's] request was for Seroquel and Tylenol. I believe [they were] brought in by ambulance." * "[The patient's] behavior was very similar to how [they have] presented in the past. I didn't think that [their] behavior was different than how [the patient] normally acts." * "We all didn't know what to do with [Patient 21]. [They are] always oriented to not be on a hold but clearly has severe mental illness and clearly not able to function as an outpatient. We are taught by law and multiple other cases, can't put people on a hold in these situations. This has been the chronic issue with [Patient 21] for the longest time. The social worker ... was doing phone calls after the patient was discharged. Up until recently, they [not specified] had been supportive to not put [the patient] forceably under treatment or hold. This was the first time that they all [not specified] felt that [the patient] had crossed	A2406		

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A2406	Continued From page 92	A2406		

threshold or had evidenced need for a hold. Unfortunately, [the patient] had already left so that judgement came a little too late. I asked the SW to put a note in the chart that the next time [Patient 21] presents, that we put [them] on a NMI and keep [the patient] against [their] will. We predicted that [the patient] would show up again that day and [they] did. With the support of [the patient's] outpatient providers, we pursued a hold. [Patient 21] had a fever so I also pursued that.
* "[Patient 21] has been difficult. It is complicated by the fact that [the patient] is also very violent and verbally abusive. If [they are] in the waiting room [they are] scaring the bejeezus out of everyone else in the waiting room as well. Apparently during [their] first visit, one of the reasons that we had to move [them] away from the waiting room was that [they were] scaring others in the waiting room. [Patient 21] is very scary. If you go up and ask [them] what you can help [them] with. One of the waiting room patients asked what they could do to help and became very aggressive and terrified that other patient [sic]. [Patient 21] is one of those cases where you are stuck between a rock and a hard place, can't win either way. You can't force treatment on [them] and yet that looks like neglect. [They have] enough ability to make decisions by [themselves]. They frown upon us doing unnecessary holds. At the same time, [they are] very mentally ill and clearly needs [sic] treatment. When I try and offer [the patient] what [they need], [the patient] becomes violent and verbally abusive. I can't offer [them] what [they need] because [they don't] want it; yells and cusses at us and is super agitated. I don't know what to do with [Patient 21] when [they are] like that. None of us did. Look at [the patient's] chart. Every ED has found problematic in the same way. We would like to treat [the

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A2406	Continued From page 93 patient] but we can't. We would like to offer [them] things but we can't because [the patient] specifically asks us not to." * "I knew that [they] had been there before in the morning. I believe [they were] brought in by ambulance I would have to check my notes I'm not sure what [they were] brought in for. I saw that [they] had been in there early that morning but I didn't dive deep into [the] chart ... I did not go into detail about what testing they had done when [they were] in just previous." 8.i. In regard to MD A's description that Patient 21 was scaring visitors and patients in the WR/lobby, the video recording described in this finding showed the time the patient entered the WR/lobby was at 1402 and the time the SOs removed the patient from the WR/lobby was at ~1447. During the time the patient was observed in the WR/lobby there were ~ twelve or more adult patients/visitors at any given time who also sat in chairs in the WR/lobby, or who were observed to come and go. The patient's mouth could be observed to open and shut as if talking. Otherwise the patient exhibited no physical behaviors. Two such persons sat a few feet from where the patient sat for an extended period. Numerous persons were observed to look at screens, text, or talk on cell phones. Others who sat together talked to the person sitting next to them. One person approached the patient, sat next to them for a few seconds, talked to the patient then moved back to their seat. Although there was no audio on the video recordings, there were no persons in the WR/lobby who were observed to exhibit non-verbal expressions of anxiety or fear of the patient, including those persons who sat nearest the patient.	A2406		

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A2406	Continued From page 94 8.j. An undated PMH internal investigation document titled only "[Patient 21's name and MRN #] included the following: "During [2024] visit [1404 to 1644] [MD A] did not do an assessment in ambulance bay and ordered Tylenol and Seroquel and ok'd patient to dc." ********** 9.a. The central log for Patient 21g reflected that they presented to the ED a third time on 2024 at 1644 with a "Chief Complaint" of "Possible Sepsis." The "ED Disposition" on the log was "Transfer to Another Facility" on 2024 at 2232. 9.b. The medical record for Patient 21g's third 2024 ED encounter was reviewed and included the following information that reflected the culmination of Patient 21's previous five visits: * An AMR ambulance report reflected that on 2024 at 1548 EMS "Arrived to find [Patient 21g] sitting up on sidewalk under a bus shelter. Just in front of [PMH]. Pants down exposing backside. Passer by called ... after finding patient like this and patient told [passerby] [patient] was pushed down by someone. Patient says [they] cannot get up. AMR offered the patient help and [they] agreed to have help up and get on the gurney. Patient is hot to the touch. Incontinent to urine. There is feces on foot and apparently on ... cheek. AMR suggested [patient] be transported to hospital and patent's mood changed and [they] shouted that [they] would not go to hospital only [LEMC UCBH]. During physical exam patient was highly boisterous and confrontational. Sometimes allowing examination and sometimes screaming not to touch [them]. Patient refused any touching of head or torso to assess for injuries patient was	A2406		

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A2406	Continued From page 95	A2406		

nodding off mid sentence at times with small equal pupils ... Patient was making delusional statments [sic] that AMR crew had pushed [them] down. Making delusional statements about restaurants and people which were not logical. Patient not oriented to year or event. Patient was informed that [they were] too sick and confused to refuse transport and we would be going to hospital for evaluation. After that, at one point patient became impatient and demanded we start going now. Patient nodded off during transport. Patient was assisted to bed at ED and care transferred to ED staff. Primary impression: Neurological. Altered mentation. Secondary impression: Other - Flu-like symptoms/acute febrile illness." The AMR report reflected the unit arrived at PMH at 1619.

* Patient 21's temperature ranged from 101.7 F at admission, to as high as 103.5 F during the encounter.
* The patient's BP ranged from 153/93 at admission, to as high as 232/142 during the encounter.
* The patient's pulse ranged from 131 at admission, to as high as 173 during the encounter.
* The patient's SpO2 ranged from 93% at admission, to as low as 89% during the encounter.
* Labwork and imaging tests revealed numerous abnormal findings.
* An "ED Behavioral Health Emergent Assessment Evaluation" was completed by an LCSW and concluded that "Due to patient's level of disorganization, inability to care for [themselves] and not being able to take medications as prescribed, I believe the patient meets criteria for Psychiatric Hospitalization at this time. Patient likely needs guardianship and

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A2406	Continued From page 96 higher level of care such as RTF. Medical work up indicates that patient will need medical admission to the hospital to rule out sepsis. Patient was placed on an NMI prior to notification that the patient will need to be medically admitted. Since patient's illness is another example of patient being gravely disabled and unable to care for [themselves] in the community NMI will be left in place for this evening. Patient will continue to receive medical treatment in the hospital, pending final psychiatric disposition for purposes of coordination of care." * A "Circuit Court and District Court of the State of Oregon For Clackamas County Notification of Mental Illness (Hospital Hold)" was completed that reflected "Patient with prior medical history of Bipolar I Disorder, Anxiety, Depression and Polysubstance Use BIBA for inability to care for [themselves]. Bystander called 911 after patient was found at a bus stop with [their] pants down. Patient was delusional and disorganized ... Patient keeps requesting to leave, [they are] unable to say how [they] would care for [themselves], appears to be off [their] medication, in [their] current stated [patient] lacks insight and is unable to engage in treatment planning." * Procedures performed included the following: - Application of "4 pt restraints," both "soft restraints" and "locking restraints," for ""violent behavior ... danger to self, danger to others" and "medical non-violent" reasons. - An intravenous line was placed. - A lumbar puncture was performed. - A urinary catheter was placed. - A nasogastric tube was placed. - An endotracheal tube was inserted and the patient placed on a mechanical ventilator. * Patient 21 was transferred at 2230 while sedated and on the ventilator by ACLS to PPMC	A2406		

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A2406	Continued From page 97 for admission to ICU. 9.c. Two PMH internal investigation documents titled "Interview with [MD A]" and dated 01/08/2024, one timed as at 1025, reflected the following information provided by MD A about their encounter/interaction with Patient 21 on [redacted]2024: In regard to the difference in the patient's presentation on this visit from the prior visit the MD A stated "There was no difference between when I saw [the patient] in the ambulance bay and when [they] presented the second time." MD A stated that "[The patient] was not different. The reason that I was able to perform the rest of [the patient's] assessment because the consensus with [their] OP providers was that [the patient] needed a hold. This was the intention. It was only after [the patient] arrived and was triaged, that [their] other medical symptoms became apparent. [Patient 21's] presentation was not any different, same behavior and same agitation. But, again, because we had the green light to put [them] on a hold this time, we did and then we were able to see the fever, tachycardia, etc. Just to give you an idea, [Patient 21] ended up, obviously if you look at the records, [they] ended up acutely encephalopathic and septic. When [they] came in, [their] agitation was really difficult to manage. Just to give you an idea, [the patient] required Herculean doses of sedatives to try and get [them] to calm down. [They] got an IM dose of Inapsine and Benadryl. [They] became even more agitated. This was because, again, [the patient] was on a NMI and being held against [their] will. This is why we don't like doing this ... [The patient's] mental status went alternating between somnolence and agitated, bizarre delirium, which required intubation. Because [the patient] was so febrile, I had to run that down,	A2406		

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A2406	Continued From page 98 including a LP. [Patient 21] ended up in the ICU because of [the] intubation. This is illustrative of how agitated [Patient 21] is and always is. [The patient] is super agitated all the time but oriented enough to force our hand into not treating [them.] Our morale is heartbroken." ********** 10.a. The "Weather Channel" website reflected that the outside temperatures in Milwaukie, Oregon, on [redacted]2023 through [redacted]2024, at the times Patient 21 was discharged and transported to the bus stop, or was parked outside in a wheelchair in the ambulance entry, ranged from 42 degrees to 48 degrees. ********** 11.a. Review of four ED encounters for Patients 3, 5, 9a, and 9b that occurred between the dates of [redacted]/2023 and [redacted]2023 reflected that those patients left the hospital without an MSE and the records lacked evidence that the hospital had not dissuaded those patients from staying. The detailed findings for those cases are found starting on Page 120 of this report under Tag A-9999.	A2406		
A2409	APPROPRIATE TRANSFER CFR(s): 489.24(e)(1)-(2) (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible	A2409		

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person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer.
The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer.

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which -
(i) The transferring hospital provides medical treatment within its capacity that minimizes the

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risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
(ii) The receiving facility
(A) Has available space and qualified personnel for the treatment of the individual; and
(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment.

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

This STANDARD is not met as evidenced by:
****
Based on interviews, review of central log and

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A2409	Continued From page 101 medical record documentation for 5 of 6 individuals who presented to the hospital for emergency services and were transferred to other hospitals for further examination or stabilizing treatment not within its capacity at the time (Patients/Encounters 1, 2, 16, 17, and 33) and review of P&Ps, it was determined that the hospital failed to fully develop and enforce EMTALA policies and procedures to ensure that it effected appropriate transfers for patients for whom an EMC had not been ruled out, removed or resolved: * Patients were transferred to other hospitals without a physician certification that included identification of patient specific and individualized benefits and risks of transfer. * Patients were transferred to other hospitals in POVs by family members, contrary to section (2) (iv) of this CFR that requires "The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer." Medical transportation with qualified personnel and equipment was not used for transfer to ensure proper monitoring and response to changes in patient condition. It was not clear whether hospital staff or the patients initiated discussions about transport by POV, and what additional risks secondary to transport by POV without qualified personnel and emergency equipment had been identified and discussed. * It was unclear whether all required and necessary medical records available at the time of transfer had been sent to the receiving hospital at the time the patient was transferred, or were provided to the receiving hospital as soon as they were available.	A2409		

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A2409	Continued From page 102 Findings include: 1.a. The P&P titled "Emergency Medical Treatment and Active Labor Act (EMTALA)" dated as "Last Revised 02/2022" was reviewed. It included the following information: * An MSE "is an exam completed by qualified medical personnel to determine whether an EMC or active labor exists." * "A LIP or qualified medical personnel will perform a MSE to determine whether an EMC exists and treat the patient or stabilize the patient's condition within the capability and capacity of the ED or L&D/Perinatal Department." * "Prior to transfer, an explanation of the need to transfer and the alternative to transfer will be made to the patient. Individualized risks and benefits will be summarized verbally and documented on the EMTALA Patient Transfer Form in the electronic medical record (EMR)." * "Stabilized patients may be transferred to another hospital if the patient so desires. Patients may be transferred (1) at their own request, (2) at the request of a legally responsible person on the patient's behalf or (3) if physician or qualified medical personnel certifies in writing that the benefits of transferring the patient to another facility outweigh the risk. 1. Arrangements for proper conveyance will then be made; a LIP or qualified medical personnel will determine the safest method of transport. 2. If a LIP or qualified medical personnel feels it is necessary for the patient's safety, they or their qualified designee will accompany the patient during transfer." * "The referring and receiving LIP share the responsibility for patient transfer and they should consult regarding the arrangements and details of patient transfer, including the method of transportation. The LIP or qualified medical	A2409		

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A2409	Continued From page 103 personnel arranging transportation is responsible for determining what additional care is required before transfer. The LIP or qualified medical personnel will also determine what transportation equipment is needed, including the use of necessary and medically appropriate life support measures during the transfer." * "Accompanying records sent with patient: 1. A copy of the ED or L&D/Perinatal Department treatment record (if applicable) 2. Flow sheet(s) 3. Laboratory results 4. X-rays 5. Progress notes 6. ECGs and/or other clinical monitoring recording 7. Transfer form(s) 8. Any other pertinent information." * "Documentation of patient transfer will be completed electronically for each transfer. The EMTALA transfer form needs to be printed from Epic after completion, signed by the patient, and sent to HIM to be included in the EMR. A copy of the form should be sent with the patient to the accepting facility." 1.b. There was no reference or acknowledgement in the EMTALA P&P that an "appropriate transfer" for patients with EMCs that had not been ruled out, removed, or resolved included, as required by section (2)(iv) of this CFR: "The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer." Further, the P&P provided no assurance that staff would not offer POV transport as an option, and there were no provisions or steps for managing cases where patients refused medical transportation and insisted on using a POV without qualified personnel and equipment. The P&P did not recognize the additional risks of transport by POV that exist in the situation where	A2409		

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A2409	Continued From page 104 a lay-person, caregiver, family member drives an individual with an EMC that has not been ruled out, removed, or resolved through the city during rush hour or in the middle of the night. 1.c. The P&P titled "Transfer of Maternal Perinatal Patient" dated as "Last Revised "10/2021" was reviewed. It included the following information: * "... the transfer shall be effected through qualified personnel and transfer equipment." * "A woman experiencing contractions is in true labor unless a qualified medical person (as defined in a hospital's medical staffing bylaws) certifies that after a reasonable time of observation the woman is in false labor." * "The transferring LIP will determine what additional care is required before transfer, mode of transfer and what equipment and capabilities should be available en route." 1.d. The "Transfer of Maternal Perinatal Patient" P&P reflected that "The transfer is effected through qualified personnel and transportation equipment" as required by section (2)(iv) of this CFR. Similar to the EMTALA P&P, this P&P also included no provisions for transfer by POV, and no steps for managing cases where patients refused medical transportation and insisted on using a POV without qualified personnel and equipment. ********** 2.a. The central log for Patient 1 reflected that they presented to the ED on [redacted] 2023 at 0105. The chief complaint was recorded as "Laboring (Possible water broke at 2330)." The disposition on the log was "Transfer to Another Facility."	A2409		

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A2409	Continued From page 105 2.b. The medical record for Patient 1's [redacted] 2023 ED encounter was reviewed and reflected the following information: * At 0117 an RN Note reflected "Pt arrives from camping stating [their] water broke at 2330 and immediately started to have contractions 3-4 minutes apart. Pt 35.5 weeks pregnant receiving prenatal care at Newberg." * At 0118 an ED Provider Note reflected "16 y.o. [sex of pt] Patient is planning on delivering in Newberg ... Patient states that [they] got up to go to the bathroom and felt a gush of fluid ... did not feel like urination ... feels like [patient] has been having contractions that are approximately 4 minutes apart ... Multiple diagnoses were considered including, but not limited to early labor, preterm rupture of membranes, urination, Braxton Hicks contractions, among others." * "[DO K] discussed the case with [MD] at PPMC who is amenable to receiving the patient in transfer for further labor monitoring and assessment of amniotic fluid presents, however as patient is local to our area and is planning on delivering in Newberg ... [PPMC MD] states that it would not be unreasonable to also let the patient him [sic] back to Newberg for assessment." * "[DO K] then discussed the case with Newberg on-call OB/GYN [MD name] who states that [MD name] is familiar with the patient, however patient has not formally established care with [MD] group in Newberg. Furthermore [MD] states the patient is actually 35 weeks and 2 days. Based on this if the patient did deliver in Newberg [MD] gives the neonate a 50-50 chance of requiring transfer to a higher level NICU center and indicates that the patient would likely be better served transferring to PPMC for labor evaluation." * "The results of [MD] conversations are described to the patient and [patient] is amenable	A2409		

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A2409	Continued From page 106 to POV transfer to PPMC." * At 0215 The ED Timeline reflected "ED Disposition set to Transfer to Another Facility." 2.c. The electronic two-page "Patient Transfer" form in Patient 1's record contained EMTALA physician transfer certification and other required documentation and included the following: * Beginning on Page 1 the form reflected: - In the space for "Reason for Transfer:" was written "Service unavailable" - In the space for "Summary of transfer benefits:" was written "Condition" - In the space for "Patient specific transfer benefits:" was written "Access to labor monitoring and OBGYN" - Pre-printed language on the form: "Summary of transfer risks: All transfers have the risk of traffic accidents, bad weather and/or road conditions as well as limitations of personnel and equipment during transport." - In the space for "Patient specific transfer risks:" was written "Delivery en route" - Patient 1's signature recorded at the bottom of page 1 was dated and timed as [redacted]2023 at 0219. * The form continued on Page 2 and reflected: - Pre-printed language on the form: "The patient will be transferred by qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures. After discussion with the receiving physician, the patient and/or family, the agreed mode of transportation is ___." Written in that space was "Private auto." - Pre-printed language on the form: "I discussed the risks and benefits with the patient/patient representative and they verbalized understanding and are in agreement with the decision to	A2409		

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A2409	Continued From page 107 transfer. By completing this form, I authorize transfer of this patient." - DO K's electronic signature recorded under those entries on Page 2 was dated and timed as [redacted]2023 at 0215. - Section IV of the form reflected "Records sent with Patient: Other (enter in comments) EMTALA." 2.d. There was no documentation on the transfer form or elsewhere in the medical record to reflect what individualized and specific risks of transfer for Patient 1 and their unborn child the DO K had "discussed." 2.e. The mode of transport decision and risk discussion for this EMTALA transfer was not clear. The transfer form reflected the "The patient will be transferred by qualified personnel and transportation equipment as required ..." However, it then reflected "Private auto" as the mode to be used which does not reflect transfer by "qualified personnel and transportation equipment." It was not clear in the medical record whether Patient 1 had been initially informed that EMS transport was to be used for this transfer as required, and whether DO K or Patient 1 initiated the idea of transport by POV. There was no documentation on the transfer form or elsewhere in the medical record to reflect that DO K had informed Patient 1 of the additional risks of transfer to themselves and their unborn child secondary to transport by POV without qualified personnel and emergency equipment through the city to the other hospital during the middle of the night. In addition, the type and extent of medical records sent was not specified to ensure all required records were sent. **********	A2409		

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A2409	Continued From page 108 3.a. The central log for Patient 2 reflected that they presented to the ED on [redacted]2023 at 1442. The chief complaint was recorded as "Abdominal Pain." The disposition on the log was "Transfer to Another Facility." 3.b. The medical record for Patient 2's [redacted]2023 ED encounter was reviewed and reflected the following information: * At 1450 an ED Triage Note reflected "Pt started having abd pain last night with some n/v. Pt was seen at UC today and encouraged to come to the ER for appy rule out. Pt ate breakfast at 1030 today and informed to stay NPO." * At 1623 "Patient roomed in ED, to room ED21." * At 1648 an ED Provider note reflected "There is area of possible hemorrhagic ovarian cyst versus active bleeding from a small pelvic vessel in the left adnexal region. I spoke with [PPMC OB] who advised obtaining a pelvic ultrasound and repeating [patients] blood work after 4 hours. Pelvic ultrasound revealed 9.7 complex left adnexal mass with blood flow internally. The left ovary cannot be distinguished from the mass along this region. Moderate amount of free fluid in the pelvis. Repeat hemoglobin hematocrit was 10.6 and 31.0. I contacted [PPMC OB] again and discussed findings with [PPMC OB]. [PPMC OB] felt patient would benefit from transfer and admission for further evaluation. I discussed findings with the patient and [the patient] was agreeable to transfer at this time. [Patient 2] remained normotensive and no findings of tachycardia or hemodynamic instability. We discussed EMS transport versus private auto where [patient's] partner would take [patient] and [patient] opted to go by private vehicle. I felt that the patient's clinical picture was most consistent	A2409		

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A2409	Continued From page 109 with left ovarian mass and nontraumatic hemoperitoneum. Advised patient not to eat or drink anything and go immediately to Portland Providence Medical Center for inpatient admission and further evaluation." * At 1706 Morphine 4mg IV and Zofran 4mg IV were documented as given. * At 1926 US Pelvis started. * At 2027 Morphine 4mg IV documented as given. * At 2150 an ED Note titled "ED Discharge Dot Phrase" reflected "Transportation mode: POV with [family member]," "Was this transportation mode determined to be the safest way to transport patient? yes" and "Pt is alert and oriented and in NAD. Pain was addressed with medication prior to discharge and pt will report directly to PPMC ED from here. Pt and [family member] instructed not to make any stops, pt not to eat or drink anything en route. Pt reminded of necessity to maintain PIV without tampering or using this on the way to PPMC." * At 2228 the ED Timeline reflected "Patient discharged." 3.c. The electronic two-page "Patient Transfer" form in Patient 2's record contained EMTALA physician transfer certification and other required documentation and included the following: * Beginning on Page 1 the form reflected: - In the space for "Reason for Transfer:" was written "Service unavailable" - In the space for "Summary of transfer benefits:" was written "Higher level of service available" - In the space for "Patient specific transfer benefits:" was written "Urgent evaluation and treatment of ovarian mass and hemoperitoneum" - Pre-printed language on the form: "Summary of transfer risks: All transfers have the risk of traffic accidents, bad weather and/or road conditions as	A2409		

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A2409	Continued From page 110 well as limitations of personnel and equipment during transport." - In the space for "Patient specific transfer risks:" was written "Worsening pain or bleeding or hypertension" - Patient 2's signature recorded at the bottom of page 1 was dated and timed as [redacted]:023 at 2220. * The form continued on Page 2 and reflected: - Pre-printed language on the form: "The patient will be transferred by qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures. After discussion with the receiving physician, the patient and/or family, the agreed mode of transportation is ___." Written in that space was "Private auto." - Pre-printed language on the form: "I discussed the risks and benefits with the patient/patient representative and they verbalized understanding and are in agreement with the decision to transfer. By completing this form, I authorize transfer of this patient." - MD B's electronic signature recorded under those entries on Page 2 was dated and timed as [redacted]2023 at 2209. 3.d. The mode of transport decision and risk discussion for this EMTALA transfer was not clear. The transfer form reflected "The patient will be transferred by qualified personnel and transportation equipment ..." However, it then reflected "Private auto" as the mode to be used which does not reflect transfer by "qualified personnel and transportation equipment." It was not clear in the medical record whether Patient 2 had been initially informed that EMS transport was to be used for this transfer as required, and whether MD B or Patient 2 initiated the idea of	A2409		

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A2409	Continued From page 111 transport by POV. There was no documentation on the transfer form or elsewhere in the medical record to reflect that MD B had informed Patient 2 of the additional risks of transfer to themselves secondary to transport by POV without qualified personnel and emergency equipment through the city to the other hospital. 3.e. During interview with EDM and QMC on 12/20/2023 at the time of the ED record review, they confirmed the lack of clear transfer risk and POV transport information in the records of Patients 1 and 2. ********** 4.a. The central log for Patient 16 reflected that they presented to the ED on [redacted]2023 at 1734 with a "Chief Complaint" of "Homeless; Mental Health Evaluation." The "ED Disposition" on the log was "Transfer to Another Facility" on [redacted]2023 at 1058. 4.b. The medical record for Patient 16's [redacted]2023 ED encounter was reviewed, reflected that an MSE was conducted by an MD, and included the following information: * At 1734 the patient's "Arrival Complaint" was recorded as "Pt unable to remain calm." * At 1740 an RN recorded that "Brought in by [family member]. Pt been homeless and unable to stay calm ... Hx schizophrenia. Not taking any meds." * At 1942 a QMHP electronically signed an evaluation that reflected "... current psychosis causing grave disability ... the patient's symptoms are considered too severe for a lower level of care as exhibited by psychotic behavior and paranoid behavior ... acutely psychotic requiring an IP setting to stabilize ... will remain in the ED	A2409		

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A2409	Continued From page 112 boarding model pending final psychiatric disposition ..." * At 2103 MD F electronically signed an "Emergency Department Provider Note" that included the following: "Clinical picture consistent with psychosis secondary to untreated schizoaffective disorder. Patient is homeless. [The patient] denies SI/HI but is not showing signs of being able to adequately care for self in the community. The patient was evaluated by social work who recommend [sic] inpatient evaluation." * On [redacted]2023 at 0005 an RN recorded that "... pt pulling hair out, when asked why pt is pulling hair pt does not respond ..." * At 0749 an RN recorded "Elopement Risk: Yes * At 1058 DO G completed and electronically signed the EMTALA "Patient Transfer" form described in the finding below. * At 1527 an RN recorded "Elopement Risk: Yes" * At 1747 an RN recorded "Patient discharged." * At 1951 MD B electronically signed a note that "Patient was placed on a transport hold. Secure transport arrived and [the patient] was discharged into their care for transfer for inpatient psychiatric admission." 4.c. The electronic two-page "Patient Transfer" form in Patient 16's record contained EMTALA physician transfer certification and other required documentation and included the following: * In the space for "Reason for Transfer:" was written "Service unavailable Patient requires inpatient psychiatric care" * Pre-printed language on the form: "Summary of transfer risks: All transfers have the risk of traffic accidents, bad weather and/or road conditions as well as limitations of personnel and equipment during transport. There is also potential for	A2409		

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A2409	Continued From page 113 worsening of medical condition during transport resulting in possible disability and/or death." * In the following space for "Patient specific transfer risks:" was written "Worsening behavior." * Pre-printed language on the form: "The patient will be transferred by qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures. After discussion with the receiving physician, the patient and/or family, the agreed mode of transportation is ___." Written in that space was "Secure transport." * Pre-printed language on the form: "I discussed the risks and benefits with the patient/patient representative and they verbalized understanding and are in agreement with the decision to transfer. By completing this form, I authorize transfer of this patient." * DO G's electronic signature recorded under those entries on Page 2 was dated and timed as [redacted]2023 at 1058. * Section IV of the form reflected "Records sent with Patient: Medical Records;" [sic] 4.d. There was no documentation on the transfer form or elsewhere in the medical record to reflect what individualized and specific risks of transfer for Patient 16 DO G had "discussed." It was not clear whether the "discussion" had occurred with the severely psychotic patient or with their representative. The physician certification of transfer risks reflected that DO G had written "Worsening behavior." However, that risk is akin to the "worsening ... condition" inherent to all transfers. It was not clear what "worsening behavior" meant in the case of Patient 16. In addition, the type and extent of medical records sent was not specified to ensure all required records were sent.	A2409		

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A2409	Continued From page 114 4.e. During interviews with the MES and the QMC at the time of the ED record reviews on 12/21/2023 beginning at 1445 no additional information regarding transfer risks was provided. 4.f. Internet/GPS distance calculators reflected that HMC in Hillsboro, Oregon was ~ 26 miles, and ~ 45 minutes drive-time in "light traffic", from PMH in Milwaukie, Oregon. ********** 5.a. The central log for Patient 17 reflected they presented to the ED on [redacted]2023 at 1759. The chief complaint was recorded as "Suicidal, Homicidal." The disposition on the log was "Transfer to Another Facility." 5.b. The medical record for Patient 17's [redacted]2023 ED encounter was reviewed and reflected the following information: * At 1809 a ED Triage Note reflected "Pt arrives with [parent], states not feeling will mentally, asks [parent] to step out of room to share info states uncomfortable with [parent] in room, pt states tried to kill myself on Thanksgiving, took [family member's] tequila, ibuprofen, wine and THC CBD gummy, no eval, reports SI denies plan but "doesn't mean I don't want to do it," reports HI against [2 family members] worse than punch them because of what they've done, no psych meds or therapist, lives with [siblings], [parent] and step [parent], not older [sibling] or bio [parent], switch custody in June, reports feels safe at home." * At 1817 "Patient roomed in ED, to room ED12." * At 1820 an RN documented an ED Quick Note that reflected "Additional Note: informing pt of POC and changing to scrubs/belongings for	A2409		

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A2409	Continued From page 115 safety, pt states [they have] a razor blade in [their] phone case, pt removed and given to RN, placed in sharps container." * At 2006 an "ED Behavioral Health Emergent Assessment Evaluation" was completed by a LCSW. The BH evaluation reflected "Formulation of plan: Due to risk of harm to self, I believe the patient meets criteria for Psychiatric Hospitalization at this time. The patient meets criteria for inpatient admission." * At 0922 on [redacted]2023 a ED Behavioral Health Reevaluation reflected "pt remains unable to safety plan for discharge. Based on current acuity of depression with recent impulsive suicide attempt and self-harm, pt continues to meet criteria for inpatient treatment. Addendum 1630: per ProvAIR, pt had been accepted for transfer to inpatient treatment at CAPU ... SW requested secure transport ..." * At 1627 on [redacted]2023 "ED Disposition set to Transfer to Another Facility." 5.c. The electronic two-page "Patient Transfer" form in Patient 17's record contained EMTALA physician transfer certification and other required documentation and included the following: * Beginning on Page 1 the form reflected: - In the space for "Reason for Transfer:" was written "Service unavailable" under this line was "Comments: Adolescent psychiatry" - In the space for "Summary of transfer benefits:" was written "Higher level of service available at receiving facility." - In the space for "Patient specific transfer benefits:" was written "Adolescent psychiatry" - Pre-printed language on the form: "Summary of transfer risks: All transfers have the risk of traffic accidents, bad weather and/or road conditions as well as limitations of personnel and equipment	A2409		

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A2409	Continued From page 116 during transport. There is also potential for worsening of medical condition during transport resulting in possible disability and/or death." - In the space for "Patient specific transfer risks:" was written "Worsening of condition" - Patient 17's Guardians signature recorded at the bottom of page 1 was dated and timed as [redacted]2023 at 1245. * The form continued on Page 2 and reflected: - Pre-printed language on the form: "I discussed the risks and benefits with the patient/patient representative and they verbalized understanding and are in agreement with the decision to transfer. By completing this form, I authorize transfer of this patient." - MD D's electronic signature recorded under those entries on Page 2 was dated and timed as [redacted]/2023 at 1628. - Section IV of the form reflected "Records sent with Patient: yes." 5.d. There was no documentation on the transfer form or elsewhere in the medical record to reflect what individualized and specific risks of transfer for Patient 17 MD D had "discussed." The physician certification of transfer risks reflected that MD D had written "Worsening of condition." However, that is risk inherent to all transfers, and it was not clear what "Worsening of condition" meant in the case of this suicidal patient. In addition, the type and extent of medical records sent was not specified to ensure all required records were sent. 5.e. During interview with EDM and QMC on 12/20/2023 at the time of the ED record review, they confirmed the lack of clear transfer risk information for Patient 17. **********	A2409		

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A2409	Continued From page 117 6.a. The central log for Patient 33 reflected they presented to the ED on [redacted]2023 at 1405. The chief complaint was recorded as "Neck Pain." The disposition on the log was "Transfer to Another Facility." 6.b. The medical record for Patient 33's [redacted]2023 ED encounter was reviewed and reflected the following information: * At 1420 an RN documented "Triage Started." * At 1422 an ED Triage Note reflected "Pt c/o sudden 4/10 neck pain starting earlier today. Recent hx of stroke and brain anyreusm [sic] stapled sx about 1x month ago, and a shunt placement about 2 weeks ago. Denies weakness/numbness." * At 1511 Lab work and CT Angio Head Neck orders were placed. * At 1659 "Patient roomed in ED, To room EDO7." * At 1713 an ED Provider Note reflected "... recent intracranial aneurysm that had a subarachnoid hemorrhage and required clipping. The patient also underwent VP shunting. The patient was just discharged from the inpatient neurosurgical stay 1 week ago ... The patient was sent for CT scan of the head which reveals a new small sub-1 cm subdural hematoma on the right. Neurosurgery from [PSVMC] was consulted and they requested the patient be transferred back to St. Vincent's for further monitoring and repeat imaging." * At 1735 "Peripheral IV Line ... placed." * At 1656 a Unit Coordinator documented "CM/SW Assessment, Planned Discharge, Transportation Will Be Provided By: taxi, Planned Transportation Date: [redacted]23, Planned Transportation Time: 2145, Ride - Contact Name: Ride to Care (taxi) [redacted]	A2409		

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A2409	Continued From page 118 2015-2145." * At 2003 Vital signs were documented as BP: 133/102, Pulse: 76, Resp: 17. * At 2119 "Patient discharged" and "Departure Condition, Mobility at Departure: Wheelchair, Departure Mode: With transport tech." 6.c. The electronic two-page "Patient Transfer" form in Patient 33's record contained EMTALA physician transfer certification and other required documentation and included the following: * Beginning on Page 1 the form reflected: - In the space for "Reason for Transfer:" was written "Service unavailable." - In the space for "Summary of transfer benefits:" was written "Higher level of service available at receiving facility" - In the space for "Patient specific transfer benefits:" was written "Neurosurgical services" - Pre-printed language on the form: "Summary of transfer risks: All transfer have the risk of traffic accidents, bad weather and /or road conditions as well as limitations of personnel and equipment during transport. There is potential for worsening of medical condition during transport resulting in possible disability and/or death." - In the space for "patient specific transfer risks:" was written "Due to time away from the acute care setting necessary to effect the transfer, the patient is at risk of clinical deterioration of the following condition(s): Subdural hematoma (HCC) (primary encounter diagnosis) Patient/condition specific risks of transfer include: Worsening subdural" - The "Patient/Guardian Signature" line was blank. * The form continued on Page 2 and reflected: - The patient will be transferred by qualified personnel and transportation equipment as	A2409		

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A2409	Continued From page 119 required, including the use of necessary and medically appropriate life support measures. After discussion with the receiving physician, the patient and/or family, the agreed mode of transportation is ALS." - Pre-printed language on the form: "I discussed the risks and benefits with the patient/patient representative and they verbalized understanding and are in agreement with the decision to transfer. By completing this form, I authorize transfer of this patient." - MD E's electronic signature recorded under those entries on Page 2 was dated and timed as [redacted]2023 1940. - Section IV of the form reflected "Records sent with Patient: yes." 6.d. The patient arrived to PSVMC in a taxi instead of the ALS transport the MD E requested. It is not clear how or why a taxi was set up for transport instead of an ambulance with proper medical personnel and equipment. The transfer form listed patient specific risks as "Subdural hematoma" which is the primary encounter diagnosis. 6.e. During interview with EDM and QMC on 02/15/2024 at 0905, they confirmed the transportation for this patient was not appropriate in this case. In addition, the type and extent of medical records sent was not specified to ensure all required records were sent.	A2409		
A9999	CLOSING COMMENTS ********** (The following findings are a continuation from Tag A-2406 regarding MSEs:	A9999		

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A9999	Continued From page 120	A9999		

12.a. The central log for Patient 3 reflected that they presented to the ED on [redacted]2023 at 2217 with a "Chief Complaint" of "Drug/Alcohol Assessment." The "ED Disposition" on the log was "Lwbs After Triage" on [redacted]2023 at 2332.

12.b. The medical record for Patient 3's [redacted]2023 ED encounter was reviewed and included the following information:
* At 2217 "Patient arrived in ED."
* At 2220 an RN documented an ED triage note that reflected "Pt BIBA, Code 1 with c/o alcohol intoxication. Per EMS, Patient has been drinking alcohol for 4-5 days in bed. Patient's last drink was immediately prior to EMS arriving. Patient's family called ambulance. Per EMS when patient withdraws from alcohol [they have] seizures but is not on medication for this. Patient wants to get checked out. Patient appears intoxicated in triage and having a separate conversation on the phone while triage Rn attempted to speak with patient. Patient placed in wheelchair d/t patient stating [they] could not stand without assistance."
* At 2227 an RN documented "Brief Assessment" and "Vital Signs."
* At 2239 an RN documented "To room RMT3."
* At 2305 Labs were collected.
* At 2330 an RN documented an ED note that reflected "Per registration, patient ambulated from RMT3 to registration and through the front doors with steady gait. Patient did not inform triage RN that [they] were leaving. MD aware."
* At 2331 ED Disposition set to "LWBS after Triage" by an RN.

12.c. The medical record lacked any documentation to reflect that attempts were made to inform Patient 3 of the risks of leaving the hospital without an MSE or that any attempts to

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A9999	Continued From page 121 obtain informed written refusal of an MSE had been made, as required by the hospital's P&Ps. 12.d. During interview with the EDM and QMC at the time of the ED record review on 12/20/2023, they confirmed that the record reflected Patient 3 had not been informed of the risks of leaving without an MSE and that informed written refusal of an MSE had not been obtained. ********** 13.a. The central log for Patient 5 reflected that they presented to the ED on [redacted]2023 at 1743 with a "Chief Complaint" of "Suicidal." The "ED Disposition" on the log was "Lwbs After Triage" on [redacted]2023 at 2015. 13.b. The medical record for Patient 5's [redacted]2023 ED encounter was reviewed and included the following information: * At 1743 "Patient arrived in ED." * At 1818 an ED Triage Note reflected "Pt comes in from home with SI and paranoia X [sic] several days. Pt tried to pour boiling water on [themselves] to harm [themselves]." * At 1820 an ED Note reflected "Pt walked out of triage when told that [they] may have to spend the night." * The next entry was recorded at 2013. * At 2013 an RN documented an ED Note that reflected "Spoke with [Significant other] who is still in lobby. Pt has left the hospital grounds. [Significant other] has been advised to call the local Police for assistance in bringing pt back into hospital and to help locate [Patient 5]. [Significant other] is agreeable, will go look for pt and call Police for assistance." * At 2015 ED Disposition set to "LWBS after Triage" by an RN.	A9999		

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A9999	Continued From page 122 13.c. The medical record lacked any documentation to reflect that a reasonable effort was made to inform the patient of the risks of leaving the hospital without an MSE or any attempt was made to locate the patient. There was no documentation that security and/or law enforcement was notified that this patient left before treatment was initiated and may be a risk for harm to self and/or others and there was no attempt at telephoning the patient at home and/or alerting authorities per the hospital's P&Ps. 13.d. During interview with the EDM and QMC at the time of the ED record review on 12/20/2023, they confirmed the record lacked the proper documentation that steps were followed per the hospital's P&Ps. ********** 14.a. The central log for Patient 9.a. reflected that they presented to the ED twice on [redacted]2023. The first visit was at 0623 with a "Chief Complaint" of "Alcohol Use" and "Withdrawal (Alcohol)." The "ED Disposition" on the log was "Lwbs after Triage" on [redacted]2023 at 1750. 14.b. The medical record for Patient 9.a.'s first ED encounter on [redacted]/2023 at 1623 was reviewed and included the following information: * At 1623 "Patient arrived in ED." * At 1634 Vital Signs obtained, BP 161/110, Pulse 94. * At 1637 an RN documented an ED Note that reflected "Pt states drinking a lot of alcohol today but states [they] have not taken [their] methadone in a few days. Pt feels like [they] are withdrawing and can't sit still in the traige [sic] chair." * The next entry was recorded at 1750.	A9999		

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A9999	Continued From page 123 * At 1750 ED Disposition set to "LWBS after Triage" by an RN. 14.c. The medical record lacked any documentation to reflect that a reasonable effort was made to inform the patient of the risks of leaving the hospital without an MSE. There was no documentation that any attempts were made to locate the patient or any information related to the circumstances of why and how the patient left the hospital. ********** 15.a. The central log for Patient 9.b.'s second ED visit reflected that they presented to the ED on [redacted]2023 at 1940 with a "Chief Complaint" of "Emesis" and "Withdrawal (Alcohol)." The "ED Disposition" on the log was "Lwbs After Triage" on [redacted]2023 at 2315. 15.b. The medical record for Patient 9.b.'s second ED encounter on [redacted]2023 at 1940 was reviewed and included the following information: * At 1940 "Patient arrived in ED." * At 1952 Vital Signs obtained and an ED Note reflected "Pt comes to ED after having withdrawal symptoms. Pt was here earlier today for the same thing but left because it took too long. Pt. [sic] states drinking a shot vodka about 1 hr ago. Hx OD taking methadone. Pt denies other drugs taken. Pt has nausea, headache and mild tremors." * At 1956 "Full Triage Completed." * The next entry was recorded at 2315. * At 2315 ED Disposition set to "LWBS after Triage" by an RN. 15.c. The medical record lacked any documentation to reflect that a reasonable effort	A9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE MILWAUKIE HOSPITAL	10150 SE 32ND AVENUE MILWAUKIE, OR 97222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A9999	Continued From page 124 was made to inform the patient of the risks of leaving the hospital without an MSE. There was no documentation that any attempts were made to locate the patient or any information related to the circumstances of why and how the patient left the hospital. 15.d. During interview with the EDM and QMC at the time of the ED record review on 12/20/2023, they confirmed the records for both Patient 9.a. and 9.b's encounters lacked any attempts to inform Patient 9 of the risks of leaving the hospital without an MSE or that any attempts to obtain informed written refusal of an MSE had been made or attempts to locate the patient.	A9999		